# EWBC DEXA BONE DENSITOMETRY

MR _____

**PLEASE DO NOT TAKE VITAMINS, CALCIUM SUPPLEMENTS, TUMS OR ROLAIDS**
***on the day of your appointment*** or we will have to reschedule your bone density appointment.
*Please continue to take all prescription medications.*

## ABOUT THIS VISIT

1. Reason for this Dexa scan: _____
2. Have you ever had a DEXA scan? ❑No ❑Yes
   If yes, ❑EWBC, when _____ OR ❑Other facility, when _____

## SOCIAL HISTORY

3. Gender: ❑Male ❑Female
4. Do you drink alcohol? ❑No ❑Yes: How often_____
5. Smoking status: ❑Current, every day ❑Current, some day smoker ❑Former smoker
   ❑Never smoker ❑Denied ❑Smoker, current status unknown ❑Unknown if ever smoked
   ❑Heavy tobacco smoker ❑Light tobacco smoker
6. Race: ❑White ❑African American ❑American Indian or Alaska Native ❑Asian
   ❑Native Hawaiian or Pacific Islander ❑Other, Race:_____
7. Ethnicity: ❑Not Hispanic/Latino ❑Hispanic/Latino
8. Preferred Language: ❑English ❑Other_____
9. Height ____ft ____in Weight _____

## QUESTIONS FOR FEMALE PATIENTS

10. Are you post menopausal? ❑No ❑Yes, age entered menopause _____
11. Hormone replacement: *Usage:* ❑never ❑unknown ❑ over 5 yrs ago ❑ less than 5 yrs ago ❑current
    *Length of time on HRT*: ____ months ____years
12. Please **check off** if you have you had any of the following:
    ❑Hysterectomy ❑Ovaries removed ❑Breast cancer ❑Cancer of the uterus ❑Blood clots
    If you "checked" any of the above questions, were you taking hormones at the time? ❑Yes ❑No

## QUESTIONS FOR ALL PATIENTS

13. **PERSONAL HISTORY** (*please check if applies to you)*

*Are you currently taking any of the following medications?*

❑ Steroids (prednisone, cortisone, etc.) How long:____

Have you taken 5mg/day or equivalent for 3 or more months? ❑Yes ❑No

| | | |
|---|---|---|
| ❑Aromatase inhibitors (Aromasin, Arimidex) | ❑Thyroid medication | ❑Actonel |
| ❑Calcitonin | ❑Prolia | ❑Anticonvulsants (for seizures, epilepsy) |
| ❑Evista | ❑Boniva | ❑Tamoxifen |
| ❑Depo-provera | ❑Fosamax | ❑Forteo |
| ❑Zometa | ❑Atelvia | ❑Reclast |

-OVER-

***14.*** *Please "check off: if any of the following pertains to YOU:*

❑Surgery on your spine or hip: Please explain _____ When _____

❑Fractured your spine or hip: where was fracture _____ When did it happen _____

❑Fractured any bones after age 40 (excluding skull, hands and feet)_____

❑Family history of osteoporosis, who: _____

❑Either of your parents had a hip fracture

❑Take a calcium supplement daily:
Dosage *per day* ❑ 0 to 500mg/day ❑501-1000mg/day ❑More that 1000 mg/day

❑Exercise at least three times per week

❑Had any contrast-media x-ray exams in the last 2 weeks (ie. barium enema or upper GI)

**15**. Have YOU had any of the following conditions:

❑Rheumatoid arthritis *(diagnosed by a physician)*

❑Other type of arthritis

❑Organ transplant recipient

❑Hypothyroidism *(under-active thyroid)*

❑Hyperparathyroidism

❑Partial or complete paralysis or immobialization due to injury

❑Part of stomach removed

❑Intestinal or bowel disease

❑Hyperthyroidism *(over-active thyroid)*

❑Heart disease

**16.** Please list all current prescription and non-prescription medications:

_____

_____

_____

_____

_____

**Print Name**:_____ **Sign Name**:_____

Today's date ____ / ____ / ____ Date of Birth: ____ / ____ / ____ E-Mail :_____