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 MALE PATIENTS

13. Do you have Hypogonadism/Low testerone level: ❑No ❑Yes

QUESTIONS FOR ALL PATIENTS

14. **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-

15. *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)_____
When did it happen? _____

❑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)

16. 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

17. Please list all current prescription and non-prescription medications:

_____

_____

_____

_____

_____

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

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