South County Internal Medicine
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Bone Density Patient History

Name: Acct.#: Date:

Social Security#: Age: Date of birth:

Height: Weight: Referring Physician:

Phone: Zip Code:

Please Circle and Give Details Where Necessary

Are You Pregnant? Y/N Which is your dominant side (hand)? R/L

Is this your first Bone Density exam? Y/N If not, which hip was done? R/L

When and where was your last Bone Density? _____

Have you had a **barium** or **nuclear medicine** in the past seven days? Y/N

Have you had hip replacement surgery? Y/N R/L

Do you have a known curvature of the spine (scoliosis)? Y/N

Have you had low back surgery? Y/N What procedure? _____

Is there a family history of osteoporosis? Y/N Which family member? _____

Do you have any known / diagnosed diseases? Y/N List_____

Are you post menopausal? Y/N At what age did menopause begin? _____

Have you had a post-menopausal fracture? Y/N Which bones? _____ Year _____

Have you had a hysterectomy? Y/N Partial or Complete? Year_____

Are you on hormone replacement? Y/N Number of years on estrogen? _____

Do you take a calcium supplement? Y/N Other medications

_____

Do you: Exercise? Y/N Consume alcohol ? Y/N Smoke? Y/N

Technologist _____