Advanced Osteoporosis Screening

National Osteoporosis Foundation Professional Partner Network Member

2305 Genoa Business Park Drive, Suite 170, Brighton, MI, 48116 (810) 299-8550

Osteoporosis Patient History Form

Please answer the following questions to help us in the treatment of your bones. If you are not sure how to answer a question, leave the space blank and we will assist you with your answer. All answers will of course be kept in strict confidence and treated as medical record information.

Name:____

Age: ________________ Height: ___________ Weight: ___________

Race: ___ African American ___Asian ___ Caucasian ___Hispanic
___ Native American ___Other: __________________________________

Sex: ___Female ___Male

Referring Physician (if any): ____

Important Questions about your Health	(Please Circle)	
Have you ever had a fracture or broken bone?	YES	NO
Did either of your parents ever fracture their hip?	YES	NO
Do you smoke?	YES	NO
Do you take glucocorticoids or steroids such as prednisone?	YES	NO
Have you been diagnosed with Rheumatoid arthritis?	YES	NO
Do you drink three or more units of alcohol (glasses, bottles, shots) on a normal day?	YES	NO
Have you had any of the following conditions?	YES	NO

If yes, please check those diagnosed

____Hyperthyroidism ____Hyperparathyroidism
____Part of your stomach removed ____Kidney Disease
____Intestinal or bowel disease ____Biliary Cirrhosis
____Eating disorders (anorexia nervosa, bulimia, etc.) ____Rheumatoid Arthritis

Have you ever been treated for Osteoporosis? (common treatments include: Fosomax, Actonel, Boniva, Miacalcin, Forteo)	YES	NO
Did you have to discontinue any of these for any reason?	YES	NO

If so, why? ____

Do you have GERD, heartburn, or history of ulcers or strictures?	YES	NO
Are you unable to swallow pills?	YES	NO
Do you have frequent nose bleeds or nasal mucosa problems?	YES	NO
Do you have severe dental problems such as abscess or extractions	YES	NO

Questions about your Calcium and Vitamin D Intake:

How many servings of dairy products do you have each day? ______________________
(one serving = 8oz. milk, 1.5oz. cheese, 8oz. yogurt, 8oz.cottage cheese, 4oz. ice cream)

Have you consumed three or more dairy servings per day throughout most of your life? YES NO

(continued on next page)

Do you take Calcium supplements daily? YES NO
If so, how many milligrams of Calcium are in your supplement? ____
How many supplements do you take per day?________________
Do you take Vitamin D supplements daily? YES NO
If so, how many international units of Vitamin D are in your supplement? ____
How many supplements do you take per day? ________________
Do you take a Multi vitamin Daily? YES NO
Do you have any general comments or questions about your health?

____

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ALL questions below ONLY required for those under 40 or over 90 years of age

Is your current body weight under 127 pounds? YES NO
Do you spend less than 20 minutes outside each day? YES NO
Is your eyesight impaired such that it interferes with walking? YES NO
Do you drink more than 2 cups of coffee or 4 cans (12oz.) of caffeinated soda per day? YES NO
Do you frequently fall or have problems with your balance? YES NO
Do you exercise less than three times per week? YES NO
If you exercise, what type typically?
____Aerobic dance ____Walking
____Weight lifting ____Jogging Other: _________________________
Does your family have a history of Osteoporosis? YES NO
Have you taken any of the following medications or treatments? YES NO
If yes, please check those you have taken
____Steroids (prednisone, cortisone, etc.) ____Lithium
____Antacids containing aluminum ____Chemotherapy
____Anticonvulsants (for seizures, epilepsy) ____Sleeping Aids
____Loop Diuretics (Lasix, Bumex, Edicrin) ____Heparin
____Methotrexate (medication for Rheumatoid Arthritis) ____Thyroid Medication
____Cholestyramine (Questran to lower cholesterol)

Questions for Women only (those under 40 or over 90 years of age)

Have you gone through menopause? YES NO
Did your menopause occur before age 45? YES NO
At what age did you go through menopause? ________________
Have you ever had amenorrhea? YES NO
(missed periods or never started periods)
Have you ever take hormones? (not including birth control pills) YES NO
If so, for how many years? _______________________________
Have you ever had your ovaries removed? YES NO

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Preparing for Bone Densitometry Scanning

- Unless instructed otherwise by one of our clinicians, eat normally on the day of the exam.
- Avoid taking calcium supplements for at least 24 hours prior to your appointment.
- Wear loose, comfortable clothing to the scan. Sweat suits and other casual attire without zippers, buttons, grommets, or any metal are preferred.
- You should not have had a barium study, radioisotope injection, oral or intravenous contrast material from a CT or MRI within seven days of your Dexa Scan test.
- You need to wait 6 weeks after a fracture before having a Dexa scan done.
- You need to be able to lay flat on your back for 20 minutes.

Please plan to schedule your follow-up appointment with our office following your scan. One of our orthopedic physicians will make recommendations for your bone health based upon not only your scan results, but also from your answers to the questions on this form, and your clinical exam. Consequently, we are unable to provide the results of the test over the phone. For this reason, it is important that you attend your follow-up appointment. We would be happy to send these results to your primary care physician. Please inform our technician, and we will send the results, along with a comprehensive letter of our recommendations, after your follow-up visit.