



TEXAS TECH UNIVERSITY  
**HEALTH SCIENCES CENTER**  
*at Amarillo*  
 Department of Obstetrics and Gynecology

Overton Osteoporosis Center  
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## BONE DENSITOMETRY PATIENT HISTORY

Please complete the following questions to the best of your ability. If you are unclear what to answer, leave the space blank and we will help with the answer when you are seen at this facility. All answers will be kept in strict confidence and treated as information in your medical record.

Your name: \_\_\_\_\_ Date: \_\_\_\_\_

1. Sex:     Female                       Male
2. Race:  African-American     Asian     Hispanic     White     Other
3. Date of birth: \_\_\_\_\_
4. If you wish a copy of your bone density report to go to an additional doctor, please give us his/her name: \_\_\_\_\_ and address: \_\_\_\_\_

5. The following medicines and supplements may be used to treat osteoporosis.. Please place a check beside each one you are taking:

**CALCIUM SUPPLEMENTS**

- Taking calcium but dose unknown     1000-1499 mg per day  
 500-999 mg calcium per day             1500 mg or more calcium per day

VITAMIN D: \_\_\_\_\_ I.U. per day

**HORMONES**

- estrogen (Premarin, Ogen, Estrace, Estraderm or Vivelle or Climara patch, etc.)  
 estrogen & progestin (prempo, Premphase, Premarin & Provera, CombiPatch, estrogen and Prometrium, Femhrt, Ortho-Prefest, etc.)  
 estrogen & testosterone (Estratest)

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- natural hormones (DHEA, Tri-estrogen, Progest, Progesterone, Soy, Black Cohosh, etc.)
- hormone creams (prescribed)

**Other medications that affect bone health:**

- alendronate (Fosamax)
- risedronate (Actonel)
- calcitonin (Calcinar, Miacalcin)
- parathyroid hormone (Forteo)
- Letrozole (Femara)
- fluoride (prescribed)
- ibandronate (Boniva)
- etidronate (Didronel)
- Raloxifene (Evista)
- Tamoxifen (Nolvadex)
- Anastrozole (Arimidex)

**6. Please list all medications you take regularly:**

Medication	Reason for taking

- |  | <u>Yes</u>               | <u>No</u>                |
|--|--------------------------|--------------------------|
| 7. Have you ever had cancer? If yes, what type and when?<br>_____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you have a fair complexion?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever fractured any bones?<br>If yes, which bone? _____<br>At what age? _____<br>How? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you have any metal implants?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have any of your relatives suffered a broken hip or shoulder,<br>lost height or had osteoporosis when past the age of 45?<br>Which relative? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you lost any of your height in the last few years?  | <input type="checkbox"/> | <input type="checkbox"/> |

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- |   | <u>Yes</u>               | <u>No</u>                |
|---|--------------------------|--------------------------|
| 13. Do you exercise less than four times per week?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Do you drink more than two alcohol drinks per day?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Have you smoked in the past?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Do you smoke currently?   | <input type="checkbox"/> | <input type="checkbox"/> |
| How much do you smoke? _____  |                          |                          |
| 17. Do you drink five or more cups of coffee or soda (containing caffeine) each day?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. How many dairy servings per day do you eat/drink? _____   |                          |                          |
| 19. Do you have partial or complete paralysis?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Do you have hyperthyroidism (overactive thyroid)?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Do you have kidney failure (on dialysis or may need it in the future?)  | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Do you have rheumatoid arthritis?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Has part of your stomach been removed (gastrectomy)?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Have you had a surgery for weight loss?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Type: <input type="checkbox"/> gastric bypass <input type="checkbox"/> banding <input type="checkbox"/> stapling <input type="checkbox"/> other _____ |                          |                          |
| 25. Do you have a serious disease of the intestines such as Crohn's disease, ulcerative colitis, or sprue?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Do you have hyperparathyroidism (over-active parathyroid gland)?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Are you now on a form of cortisone (such as prednisone) or have you taken it for more than three months in the past?                              | <input type="checkbox"/> | <input type="checkbox"/> |
| What is the name? _____   |                          |                          |
| What is the dose? _____   |                          |                          |
| What is it for? _____   |                          |                          |
| Is it injection, nasal inhalant, cream or pill? _____   |                          |                          |
| How long have you been on it? _____   |                          |                          |
| 28. Have you ever had a venous thrombotic event such as:  |                          |                          |
| Stroke  | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood clot (thrombosis or thrombophlebitis)   | <input type="checkbox"/> | <input type="checkbox"/> |
| Pulmonary embolism  | <input type="checkbox"/> | <input type="checkbox"/> |
| Retinal vein thrombosis   | <input type="checkbox"/> | <input type="checkbox"/> |

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- |  | <u>Yes</u>               | <u>No</u>                |
|--|--------------------------|--------------------------|
| 29. Are you or have you ever taken an anticoagulation drug (i.e., Coumadin, Heparin, or Lovenox?)<br>If so, when and for how long? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Have you had any testing or procedure within the last 7 days using contrast dye such as for IVP, barium enema or upper GI x-rays?    | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Have you had a nuclear medicine scan in the last 7 days?<br>If yes, what type? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. What is your tallest lifetime height measured in stocking feet?<br>_____   |                          |                          |

**FEMALES ONLY:**

- |   |                          |                          |
|---|--------------------------|--------------------------|
| 33. Are you pregnant or do you suspect pregnancy?<br>Please indicate the first day of your last menstrual period:<br>_____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. Have you had your uterus removed (hysterectomy)?<br>If so, when was this done? _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 35. Have you had your ovaries removed (sometimes referred to as a “complete hysterectomy”)?<br>If so, when was this done? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 36. Have you stopped your periods permanently?<br>At what age? _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 37. Are you taking hormone replacement therapy?<br>If so, how long have you been taking hormones? _____<br>What hormones are you taking? _____<br>Dose and frequency: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Did you ever take hormones in the past?<br>If so, how long and when did you take them? _____<br>_____   | <input type="checkbox"/> | <input type="checkbox"/> |

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