3200290

BAILEY MEDICAL CENTER
OWASSO, OKLAHOMA 74055

IMAGING DEPARTMENT
BONE DENSITY SCREENING
200290 (06/09)

Sex: ☐ Male ☐ Female Age:____________
Race: ☐ African American ☐ Caucasian ☐ Hispanic ☐ Asian ☐ Other ____________________
Have you ever taken, or are you now taking any of the following medications?
☐ Steroids (prednisone, cortisone, etc.) ☐ Thyroid medication ☐ Anticonvulsants (for seizures, epilepsy)
☐ Fosamax ☐ Calcitonin ☐ Actonel ☐ Evista ☐ Reclast ☐ Boniva ☐ Forteo ☐ Other__________

If yes, when did you take it and for how long? ______________________________

Do you have a family history of breast cancer? If yes what relationship and age?.......... ☐ Yes ☐ No
Self - age_______ Mother - age_______ Sister - age_______ Daughter - age_______
Grandmother - age_______ Other ______________________ age_______

Have you ever had surgery on your spine or hip? .... ☐ Yes ☐ No
If yes, which area? ____________________ When did it happen? __________

Have you ever fractured any bones during your adult life?.......... ☐ Yes ☐ No
If yes, what bone did you fracture? ____________________ When did it happen? __________

Do you have a family history of osteoporosis?.......... ☐ Yes ☐ No
If yes, who in your family has osteoporosis?____________________

Do you currently smoke more than ½ pack of cigarettes per day?.......... ☐ Yes ☐ No
Have you smoked in the past?.......... ☐ Yes ☐ No
Do you take a calcium supplement daily?.......... ☐ Yes ☐ No
If yes, how much? ☐ 0-500mg/day ☐ 501-1000mg/day ☐ more than 1000mg/day
Do you exercise at least three times per week? .... ☐ Yes ☐ No
Do you drink more than two alcoholic drinks per day.......... ☐ Yes ☐ No

Have you had any of the following conditions?
☐ Rheumatoid arthritis ☐ Partial or complete paralysis or immobilization due to injury
☐ Hyperthyroidism (over-active thyroid) ☐ Hypothyroidism (under-active thyroid)
☐ Hyperparathyroidism ☐ Part of stomach removed (Gastric Surgery) ☐ Kidney disease
☐ Intestinal or bowel disease ☐ Heart disease ☐ Organ transplant recipient
☐ Other type of arthritis____________________

Have you had any contrast-media (dye) x-ray exams in the last 2 weeks.......... ☐ Yes ☐ No

Do you have general comments about you health?______________________________

PLEASE LIST ALL CURRENT PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS: ______________

WOMEN ONLY

Have you been through menopause?.......... ☐ Yes ☐ No
If yes, at what age did it occur?__________
Do you have amenorrhea (never started periods, or periods at a young age)? .... ☐ Yes ☐ No
Do you now take hormones (Premarin, estrogens, etc.)excluding Birth Control Pills?.......... ☐ Yes ☐ No
If yes, how long have you taken hormones? __________ When? ________ # of Years total _____
Have you had any of the following? ☐ Hysterectomy ☐ Ovaries removed ☐ Blood clots
☐ Breast cancer ☐ Cancer of the uterus
If so, were you on hormones at the time? .... ☐ Yes ☐ No

MEN ONLY ☐ **Hypogonadism / Low testosterone level**

Patient Signature ____________________

Tech Signature ____________________