Patient Sticker

HCA Va Independence Park Imaging Center
An HCA affiliate

BONE DENSITY PATIENT MEDICAL HISTORY

Please read carefully. Complete FRONT & BACK in its ENTIRETY

Name: _____ Height: _____ Weight: _____ lbs. Age: _____ yrs.

Race: □ White □ Black □ Hispanic □ Asian □ Other _____

Sex: □ Female □ Male Right or Left Handed □ Right □ Left

Have you had a DEXA Bone Mineral Density exam before? □ Yes □ No

If yes, when and where: _____

Is this exam for □ **Osteoporosis Screening** OR □ **Monitoring Osteoporosis Treatment**

Other reason for exam today? _____

Yes	No	**MENOPAUSE** (Questions for female patients only)
□	□	Are you postmenopausal (Have you stopped having a period?)
□	□	Did you have both of your ovaries removed?
□	□	Is there a chance you could be pregnant?

Yes	No	**OSTEOPOROSIS RISK FACTORS**
□	□	Do you drink three or more alcoholic drinks every day?
□	□	Do you have a family history of Osteoporosis?
□	□	Has either of your parents fractured their hip without major trauma?
□	□	Do you take steroids regularly (≥5 mg of prednisone per day for at least 3 months)
□	□	Do you have a history of fracture; hip, spine, shoulder or forearm without trauma
□	□	Do you have a history of any of the following? (Check all that apply)
		□ Diabetes Type 1 □ Premature menopause (≤ 45) □ Hyperparathyroidism
		□ Crohn's, Ulcerative colitis □ Chronic antiseizure medication □ Hypogonadism
		□ Breast Cancer Chemotherapy
□	□	Have you been diagnosed with Rheumatoid Arthritis?
□	□	Do you currently smoke tobacco?
□	□	Have you lost two inches or more in height since high school?

Yes	No	**OSTEOPOROSIS**
□	□	Have you been diagnosed with Osteoporosis?
□	□	Are you being medically treated for Osteoporosis or Osteopenia (other than Calcium)?
		If YES, which medication(s) are you taking and for how long?
		□ Fosamax, Fosamax plus D, Dinosto _____ □ Boniva _____
		□ Actonel, Atelvia _____ □ Forteo _____
		□ Miacalcin, Fortical, Calcitonin _____ □ Evista _____
		□ Reclast, Zometa _____ □ Prolia _____
		□ Estrogen or Hormone Replacement Therapy (list) _____
		□ Other _____

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OTHER INFORMATION

Have you had prior surgery to your: (check all that apply)

□ Right Hip □ Left Hip □ Lumbar Spine □ Right Wrist □ Left Wrist

Additional Notes:

_____

_____

_____

_____

_____

_____

I have read and completed the above questions on the Bone Density Medical History form. I have been provided the opportunity to ask any questions I may have. I verify this by signing below.

_____ _____

Patient or Authorized Representative Date

_____

If not patient, relationship to patient

FOR TECHNOLOGIST USE ONLY

By signing below, I acknowledge the following:

1. I have reviewed the above information on Bone Density Medical History with the patient in its entirety.
2. I provided the patient an opportunity to ask any questions he/she may have.

Reviewed by: _____

Signature: _____ Date: _____