



**Potomac Valley Orthopaedic Associates
Bone Densitometry – Patient History**

Name: _____ **Date:** _____
Birthdate: _____ **Age:** _____

HT: _____ **WT:** _____ **Referring Doctor:** _____
Primary Care Physician: _____

Is this your first bone density exam? __ Yes __ No
Where was you last exam? _____
Which area was scanned on the last exam? _____
Have you had a contrast (barium) or nuclear medicine (isotope) exam in the past 7 days: _____

Have you had hip replacement surgery? __ Yes __ No
Have you had back surgery? __ Yes __ No
Do you have a curvature of your spine (scoliosis)? __ Yes __ No

Are you having pain? __ Yes __ No
If yes, where? _____
Ethnicity: _____

Perceived Height Loss? ___ Inches ___ None ___ Don't Know

MEDICAL History

- | | |
|---|---|
| ___ Insulin Dependant Diabetes Mellitus | ___ Kidney Disease - Dialysis ___ |
| ___ Thyroid Problems | ___ Liver Disease |
| ___ Hyperparathyroidism | ___ Epilepsy |
| ___ Inflammatory Bowel Disease | ___ History of Anorexia |
| ___ Celiac disease (gluten intolerance) | ___ History of irregular menstrual cycles |
| ___ Rheumatoid Arthritis | ___ Vitamin D deficiency |
| ___ Multiple Sclerosis | ___ History of fractures When _____ |
| ___ Asthma or COPD | |
| ___ Prolonged Bed Rest | ___ History of Cancer – Type _____ |
| ___ Other _____ | ___ History of Radiation treatment |
| | ___ Paget's disease |

SOCIAL History

Y N Alcohol Consumption: ___ <2 drinks per day ___ > or equal to 2 drinks per day
Y N Tobacco Use: ___ # packs per day ___ # years
Y N Caffeine Use: ___ # cups of coffee ___ # cans of soda/day
Y N Low Lifetime Intake of Calcium

FAMILY History

- ___ History of fractures
 ___ History of osteoporosis

SURGICAL History

- ___ Hysterectomy Date: _____
 ___ Thyroid surgery Date: _____
 ___ Gastric Bypass Date: _____
 ___ Other Date: _____

ALLERGIES to Medications: _____

MEDICATIONSDoseDate Started

Are you taking or have taken in the past

Y N Hormone Replacement Therapy _____
 Y N Depo-Provera _____
 Y N Calcium _____
 Y N Vitamin D _____
 Y N Fosomax/Actonel/Zometra/Boniva _____
 Y N Raloxifene _____
 Y N Calcitonin _____
 Y N Antacids _____
 Y N Synthroid _____
 Y N Steroids (Prednisone) _____
 Y N Asthma medication _____
 Y N Diuretics _____
 Y N Anticonvulsants _____
 Y N Tamoxifen _____
 Y N Lithium _____
 Y N Ariimedex _____
 Other Medications not listed _____

“Review Of Systems” will NOT be reviewed by a Physician today; if you are experiencing any acute symptoms, please notify a staff member or your Primary Physician.

REVIEW OF SYSTEMS:

Do you currently experience any of the following? (check all that apply)

If none apply, please check here

General

weight loss
 fevers
 fatigue

Eyes

glasses
 contacts
 glaucoma

Skin

rash / sores
 psoriasis

Cardiovascular

chest pain
 irregular rhythm
 heart murmur

Ears/Nose/Throat

hearing loss
 sinus infections

Hematologic

bleeding problems
 blood clots

Gastrointestinal

heartburn w/ aspirin
 stomach ulcers
 hepatitis

Respiratory

shortness of breath
 sleep apnea

Immunologic

tuberculosis
 HIV infection

Musculoskeletal

arthritis
 osteoporosis
 prior fracture

Urinary

painful urination
 urinary infection

Psychiatric

depression
 anxiety

Neurologic

balance problems
 dizziness
 weakness
 headaches
 seizures

Endocrine

thyroid problems
 diabetes

Women onlyPregnant yes noBreast Feeding yes no

Date of last menstrual period: _____

To the best of my knowledge, the information provided is accurate.

Patient/Responsible Party signature: _____ **Date:** _____

MD signature: _____