

GHENT FAMILY PRACTICE, INC.
3535 Granger Road
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BONE DENSITY TEST
PATIENT HISTORY

Please answer the following questions. If you are not sure how to answer a question, leave the space blank and we will assist you with the answer when you are seen for your Bone Density test. All answers will be kept in strict confidence and treated as medical record information.

1. Name: _____ Date of Birth: _____
2. Race: African American Asian Caucasian Hispanic Native American Other
3. Sex: Female Male
4. Height: _____ Weight: _____
5. Referring Physician (if any) _____
6. Have you fractured any bones in your adult life? Yes No
7. Does your family have a history of osteoporosis? Yes No
8. Do you smoke more than a half of a pack of cigarettes per day? Yes No
9. Have you smoked in the past? Yes No
10. Do you have three or more servings of dairy products every day? Yes No
(One serving=8oz milk, 1.5oz cheese, 8oz cottage cheese, or 4oz ice cream)
11. Have you consumed three or more dairy servings daily throughout most of your life? Yes No
12. Do you take a calcium supplement daily? Yes No
If so, how much? 0-500mg/day 500-1000mg/day >1000mg/day
13. Do you exercise at least three times per week? Yes No
14. Do you drink more than two alcoholic beverages (1 ½ oz each) per week? Yes No
15. Have you taken any of the following medications or treatments?
- a. Corticosteroids (Prednisone, cortisone, etc.) Yes No
 - b. Thyroid medication Yes No
 - c. Anticonvulsants (for seizures, epilepsy) Yes No
 - d. Loop diuretics (Lasix, Bumex, Edicrin) Yes No
 - e. Heparin Yes No
 - f. Chemotherapy Yes No
 - g. Lithium Yes No
16. Have you had any of the following conditions?
- a. Hyperthyroidism or Hyperparathyroidism? Yes No
 - b. Biliary Cirrhosis Yes No
 - c. Kidney disease Yes No
 - d. Rheumatoid arthritis Yes No
 - e. Other arthritis Yes No
 - f. Part of stomach removed Yes No
 - g. Intestinal or bowel disease Yes No
 - h. Eating disorders (anorexia nervosa, bulimia, etc.) Yes No
17. Do you have any general comments or questions about your health? _____
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REMAINING QUESTIONS ARE FOR *WOMEN* ONLY

18. Have you gone through menopause? Yes No
19. Did your menopause occur before age 45? Yes No
20. Have you ever had amenorrhea (missed periods or never started periods)? Yes No
21. Have you ever taken hormones (not including birth control pills)? Yes No
If so, for how many years? _____
22. Have you ever had any of the following side effects from hormones?
- a. Breast tenderness Yes No
 - b. Heavy periods or intermittent bleeding/spotting Yes No
 - c. Headaches Yes No
 - d. Weight gain or fluid buildup Yes No
 - e. Other Yes No
23. Have you ever been treated for osteoporosis or weak bones? Yes No
If so, what was the treatment? _____
24. Have you ever had any of the following conditions?
- a. Hysterectomy (womb removal) Yes No
 - b. Ovaries removed Yes No
 - c. Blood clots Yes No
If yes, were you on hormones at the time? Yes No
 - d. Breast cancer Yes No
 - e. Family history of breast cancer Yes No
 - f. Cancer of the uterus (womb) Yes No

Date of last Bone Density test: _____ Facility/Office performed at: _____

I have been informed that my Bone Mineral Density test may not be covered by my insurance policy and I agree that the full amount is due and payable by me at the time of service.

Signature: _____

Date: _____

Print Name: _____

Witness: _____

Follow up appointment: _____