RHEUMATOLOGY CONSULTANTS, LLP

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RHEUMATOLOGY
OSTEOPOROSIS
FELLOWS, AMERICAN COLLEGE OF RHEUMATOLOGY

DEXA - Bone Densitometry Lab - Patient History

Patient's Name: _____

Age _____ Sex:____Height: _____Weight:_____

Primary Care Physician:_____

Any significant active dental problems?

_____

Questions For Women Only:

Menopause:

Age at onset: _____ Natural or surgical?_____

Taking Estrogen or considering Estrogen Therapy?

_____

If pre-menopausal, are periods regular?_____

Are you pregnant or is there a chance you may be pregnant?

_____

For All Patients:

List Medications:_____

_____

_____

Supplemental Calcium (yes or no, amount & how long?)

_____

Vitamin D (yes or no, Amount/For how long?)

_____

Past history of Dilantin/Cortisone/Heparin? _____

Current or Past History of Steroids? (ie.Prednisone/Medrol)

_____

Any medication allergies? _____

Any lactose or milk allergies?_____

Any intestinal disorder or abdominal surgery?_____

If so, describe _____

Any lower back or hip surgery? _____

If so, describe _____

Any problems with your esophagus (swallowing tube) such as reflux ulcer or achalasia? If so, describe _____

_____

Bone Health:

Any family history of Osteoporosis?
(yes or no, and relationship) _____

Are you currently taking any anti Osteoporosis Treatment? _____

Any fractures or dislocations? Y/N
At what age? _____
Cause of injury? _____

_____

Exercise habits: _____

Has your posture changed? Y/ N

Smoking (yes or no, and amount)

_____

If you quit, when? _____

Alcohol (yes or no, and amount)?

_____

Any history of:
(If yes, please elaborate)

Weight Loss.....	yes	no
Heart Disease.....	yes	no
Phlebitis.....	yes	no
Blood Clots.....	yes	no
Thyroid Disease.....	yes	no
Parathyroid Disease.....	yes	no
Kidney Disease.....	yes	no
Kidney Stones.....	yes	no
Back Pain.....yes		no
Anorexia Nervosa.....yes		no
Colitis/Crohn's Disease.....	yes	no
Any cancer or tumors?	yes	no

(If so, what type?) _____

_____

Any family history of breast cancer?
(yes or no, and relationship) _____

_____

Reason for Bone Density Testing?

_____

Date of last DEXA scan: _____

Physician Signature: _____

Date: _____

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