Natchitoches Regional Medical Center
Radiology Department
Bone Density Worksheet

PATIENT NAME: ____________________________________ ADDRESS:
____
CITY:
____________________________STATE:________________ZIP:________________________________
____
RACE: ___________BIRTHDATE:_____________________AGE:_________M/
F_________HT.________WT.________
SSN: _________________________________PATIENT NUMBER:
____
REFERRD BY DOCTOR: ______________________________________

HAVE YOU EVER HAD A BONE DENSITY STUDY DONE? NO YES
IF YES, WHEN AND WHERE?
____

MEDICAL HISTORY
Have you lost height? NO YES
Since the age of 25, have you broken any bones? NO YES
Please circle: Spine Hip Hand Wrist Ribs Pelvis Foot/Ankle
Other_______________________

Have you had any of the following problems? (Please circle)

Arthritis	Kidney Stone	Alcoholism	Uterine Cancer	Cervical Cancer
Lupus	Liver Disease	Diabetes	Breast Cancer	Anorexia
Malabsorption	Kidney Disease	Thyroid Disease	Parathyroid Disease	Colon Cancer
Back Pain	Osteoporosis	Osteopenia	Ovarian Cancer	

Have you taken any of the following medications for an extended period of time (more than 6 months)?

Steroids (Cortisone,Predisone,Deltasone)	NO	YES
Thyroid medication	NO	YES
Seizure or Anti-Consultant Medication	NO	YES

Are you taking any of the following medications?

Estrogen (Hormone)	NO	YES	How long? _________________
Evista	NO	YES	How long? _________________
Fosamax	NO	YES	How long? _________________
Didronel	NO	YES	How long? _________________
Miacalcin	NO	YES	How long? _________________
Calcimar	NO	YES	How long? _________________
Boniva	NO	YES	How long? _________________
Actonel	NO	YES	How long? _________________
Calcitonin	NO	YES	How long? _________________

List all other medications you are taking:
____
____
___
____
___

********************PLEASE COMPLETE THE OTHER SIDE OF THIS PAGE********************

Lifestyle/Nutrition	NO	YES
Do you smoke?	_____	_____
Did you smoke in the past?	_____	_____
Do you exercise on a regular basis? (About 3 times a week)	_____	_____
Do you eat dairy products frequently? (About 3 or 4 servings per day)	_____	_____
Do you take calcium supplement? (Ex: Os-Cal, Tums, Caltrate)	_____	_____
Do you drink more than 5 cups of coffee a day?	_____	_____
Do you take a multivitamin or Vitamin D supplement?	_____	_____

FOR WOMEN ONLY

	NO	YES	
Have you had a hysterectomy?	______	______	Age_________
Have you gone through menopause?	_______	_______	Age_________
Have your ovaries been removed?	_______	_______	
Were you under 16 when your cycles started?	_______	_______	

Family History

Any female relative had broken wrist, hip, or spine after age 45 years old? NO YES

Any female relative lost height or stooped over later in life? NO YES

Any female member diagnosed with osteoporosis? NO YES

Any female history of breast cancer? NO YES

Recent History

Any x-rays performed in the last 5 days with oral contrast media? NO YES
(Ex: CAT scan, UGI, BE)

Any radioactive studies in the last 3 days? NO YES
(Ex: Nuclear Medicine study)

Any low back surgery? NO YES

Any metal object in the abdominal area? NO YES

Have you surgery on either hip? NO YES If YES, which side? Right Left