BONE DENSITY HISTORY FORM

Carol Milgard Breast Center
A CHI Franciscan—MultiCare—TRA Collaboration

Name: _____ Date of Birth: _____

Patient ID: _____ Sex: ❑ Female ❑ Male ❑ Other

Current Height (in): _____ Weight (lbs): _____ Menopause Age _____ Ethnicity _____

1. Have you had a previous hip or vertebral fracture or surgeries? ❑ Yes ❑ No
2. Have you had any fractures as an adult not caused by an injury or fall? ❑ Yes ❑ No
3. Did either of your parents ever have a hip fracture? ❑ Yes ❑ No
4. Do you currently smoke? ❑ Yes ❑ No
5. Have you ever taken Glucocorticoids/Steroids (i.e. Prednisone, etc.)? ❑ Yes ❑ No If yes: ❑ Oral ❑ Inhaler
6. Do you have rheumatoid arthritis? ❑ Yes ❑ No
7. Do you have secondary osteoporosis (caused by medical treatment)? ❑ Yes ❑ No
8. Do you currently drink 3 or more alcoholic beverages a day? ❑ Yes ❑ No
9. Are you being treated for osteoporosis? ❑ Yes ❑ No
10. Please indicate with a check mark if you have ever taken any of the following medications:

❑ Actonel (risedronate)	❑ Boniva (ibandronate)	❑ Letrozole
❑ Evista (raloxifene)	❑ Forteo	❑ Fareston
❑ Fosamax (alendronate)	❑ HRT (estrogen/hormone therapy)	❑ Aromasen
❑ Miacalcin (calcitonin)	❑ Protelos (stronium ranelate)	❑ Tamoxifen
❑ Reclast (zoledronate)	❑ Prolia	❑ Femara
❑ Vitamin D	❑ Calcium	❑ Arimidex

❑ Other (specify): _____

11. Please indicate with a check mark if you have any of the following medical conditions:

❑ Anorexia or bulimia	❑ Any seizure disorders	
❑ Asthma or emphysema	❑ Cancer (list type) _____	
❑ End stage renal disease	❑ Inflammatory bowel diseases	
❑ Hyperparathyroidism	❑ Osteopenia	❑ Osteoporosis

❑ Other (specify): _____

12. What was your maximum height (inches)? _____
13. Do you perform weight bearing exercises regularly? ❑ Yes ❑ No
14. Do you regularly consumer dairy products? ❑ Yes ❑ No
15. Do you drink caffeinated beverages? ❑ Yes ❑ No

If female:

16. At what age did your period start? _____
17. Are you pre-menopausal? ❑ Yes ❑ No
18. How many full-term pregnancies have you had? _____
19. Have you ever missed your period more than six months in a row (not including pregnancy or menopause)? ❑ Yes ❑ No
20. Are you post-menopausal? ❑ Yes ❑ No
21. Have you had a hysterectomy? ❑ Yes ❑ No
22. Have your ovaries been removed? ❑ Yes ❑ No

_____ _____ _____

Signature Date Technician