Name: ___________________________ Height: _____ ☐ in ☐ cm Weight: _____ ☐ lb ☐ kg Ethnicity: ___________

YES	NO	
		Are you or is there a chance that you could be pregnant? *1
		Have you had any Barium Studies, X-ray dye, or Nuclear Medicine injections in the last 2 weeks? *2
		Have you had Calcium supplement today? *2
		Do you smoke or have you previously smoked (1/2 pack or more a day)?
		Do you drink beverages containing alcohol (2 or more a day)?
		Do you consume dairy products (3 or more a day)?
		Do you consume caffeine regularly?
		Do you exercise (3 or more times a week)?
		Do you have scoliosis?
		Do you have back pain? If yes, Upper or Lower
		Are you currently wearing a blood glucose monitoring or medication delivery system (i.e., Neulasta OnPro, FreeStyle Libre, V-Go, etc.)?

Have you had a previous Bone Density? _________ When _________ Where ______________________________

YES	NO	
		Has anyone in your family been diagnosed with osteoporosis (mother, grandmother, aunt, sister)?
		Have you noticed a loss in height? If yes, what was your maximum height?
		Have you had back surgery? If yes, were pins or metal screws used? Yes or No
		Have you had hip surgery? If yes, was metal used? Yes or No Right or Left

Are you taking or have you ever taken the following medications:

YES	NO		Yes	No	
		Osteoporosis Medications (ex: Evista, Fosamax Actonel,Forteo, Boniva, Reclast, Calcitonin)?			Hormone Replacement Therapy, Birth Control, Estrogen
		Steroids (oral or injections)(long term greater than 3 mo)			Medication for seizures or epilepsy
		Tamoxifen or other Anti-Cancer meds			

Have you ever had or been diagnosed with any of the following?

YES	NO		YES	NO		YES	NO	
		Broken Bones (adult)			Hyperthyroid			Renal Failure or Dialysis
		Blood Clots			Hyperparathyroid			Renal osteodystrophy
		Osteoporosis			Rheumatoid Arthritis			Eating Disorder
		Seizures or epilepsy			Cushing's Disease			Organ Transplant
		Asthma			Intestinal Bowel Diseases			Breast Cancer
		Diabetes			Celiac Disease			Other Cancer

Please list other Medications you are taking that are not checked off above: ______________________________
____

Female Only
Have you reached menopause? _________ Age of menopause _________ ☐ Natural ☐ Chemical
Have you had a hysterectomy? _________ Were your ovaries removed _________ Age _________
Have you ever missed your menstrual period for more than six months in a row, except pregnancy? ____________
Number of full term pregnancies, if any? _________

Male Only
Have you been diagnosed with prostate cancer? _________ Age when diagnosed _________
Have you had a castration procedure for prostate cancer? _________
Have you been diagnosed with hypogonadism? _________

*1 __________________The use of ionizing radiation during pregnancy is contraindicated. Consult with physician.
*2 ____ Consult with physician.

Patient Signature	Date/Time

Patient Label