



DT904

Atlantic Health System

OSTEOPOROSIS DATABASE

Name: _____ Date: _____

Date of Birth: _____ Home Phone: _____ Cell/Work Phone: _____

Referring Physician: _____ Other Physician(s): _____

Male Female Weight: _____ Height: _____ Reason for Exam: _____

Race: Asian Black Hispanic White Other: _____

Have you had a bone density exam in the past?

No Yes: When: _____ Where: _____

Are you currently pregnant: Yes No

Are you: Pre-Menopausal Peri-Menopausal **Date of last menstrual period:** _____

Post-Menopausal Premature Menopause (Under age 45) **Age at menopause:** _____

Have you had:

A nuclear medicine exam within the last 3 days Yes No

A barium study within the last 7 days Yes No

Any hip surgery Yes No

Any fracture repair Yes No

A hip replacement Yes No

Abdominal surgery Yes No

Hysterectomy Yes No If yes, when: _____

Ovaries removed Yes No If yes, when: _____

Patient's Medical History: (Please check any conditions that apply to you)

- | | | |
|---|--|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hypogonadism | <input type="checkbox"/> Osteogenesis Imperfecta (Adults only) |
| <input type="checkbox"/> Chronic Liver Disease | <input type="checkbox"/> Loss of Height | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Cushing's Disease | <input type="checkbox"/> Malabsorption | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Diabetes - Type 1
Insulin Dependent | <input type="checkbox"/> Malnutrition Problem/
Eating Disorders | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Hyperparathyroidism | <input type="checkbox"/> Organ Transplant | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Hyperthyroidism (untreated) | | |

Fracture of: Hip Spine Wrist Other (specify) _____

How was the fracture sustained? _____ When: _____

Do you have any family history of osteoporosis? Yes No

Has either parent suffered a fractured hip? Yes No

Are you currently taking any of the following medications?

- | | |
|---|---|
| <input type="checkbox"/> Anticonvulsants (eg: Dilantin) | <input type="checkbox"/> Osteoporosis Prevention Medication (eg: Fosamax) |
| <input type="checkbox"/> Birth Control Pills | <input type="checkbox"/> Steroids (eg: Prednisone, Cortisone) |
| <input type="checkbox"/> Calcium | <input type="checkbox"/> Thyroid Medication |
| <input type="checkbox"/> Estrogen Replacement | <input type="checkbox"/> Vitamin D |

Do you: Smoke Drink 3+ alcoholic beverages per day

Exercise 2+ times per week Regularly include dairy in your diet