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

**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?**
- ☐ Anticonvulsants (eg: Dilantin)
- ☐ Birth Control Pills
- ☐ Calcium
- ☐ Estrogen Replacement
- ☐ Osteoporosis Prevention Medication (eg: Fosamax)
- ☐ Steroids (eg: Prednisone, Cortisone)
- ☐ Thyroid Medication
- ☐ Vitamin D

**Do you:**
- ☐ Smoke
- ☐ Exercise 2+ times per week
- ☐ Drink 3+ alcoholic beverages per day
- ☐ Regularly include dairy in your diet