

PATIENT INFORMATION FORM

Name _____ Date _____

Birthdate _____ Physician _____

Sex: Male _____ Female _____ Age _____ Race _____

Have you had a DEXA scan before? When and Where? _____

Have you ever smoked? _____ How many packs a day? _____ How many years? _____

Do you drink alcohol? _____ How many drinks a day? _____

Do you drink caffeine? _____ How many drinks a day? (coffee, tea, cola) _____

Do you exercise regularly? _____ How? _____ How often each week? _____

Do you have a family history of Osteoporosis? _____

Have you broken any bones? _____ Which bones? _____ What year? _____

Have you had back surgery? _____

HAVE YOU EVER TAKEN ANY OF THE FOLLOWING MEDICATIONS?

Estrogen _____ Dilantin _____ Heparin _____

Birth Control Pills _____ Tegretol _____ Lithium _____

Thyroid _____ Steroids (Prednisone) _____ Other Hormones (List) _____

Fosamax _____ Evista _____

Calcium (How Much) _____ Actonel _____

WHAT MEDICATIONS ARE YOU TAKING CURRENTLY?

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES?

Eating Disorder _____ Hyperparathyroidism _____

Diabetes _____ Liver Disease _____

Thyroid _____ Rheumatoid arthritis _____

Cancer (what type) _____ Lactose Intolerance _____

Prolonged bed rest or confinement _____ Kidney Failure _____

IF YOU ARE FEMALE PLEASE ANSWER THE FOLLOWING QUESTIONS

What age did your periods start? _____ Are (were) they regular? _____

At what age did you enter menopause? _____ Other than pregnancy, did you have any period of time where you had few or no periods? _____ For how long? _____

Have you had a hysterectomy? _____ Were your ovaries removed? _____

IF YOU ARE MALE PLEASE ANSWER THE FOLLOWING QUESTIONS

Have you ever had prostate cancer? _____ Year diagnosed _____

If so, what type of treatment? _____ Surgery _____ Radiation _____ Drugs (List) _____

Have you ever been diagnosed with testosterone deficiency? _____