Bone Density Patient Information Sheet

THE BREAST CENTER
of GREENSBORO IMAGING

Name (print): ______________________ Date: ______________

Is there a chance that you are pregnant: Yes No

Have you had a barium X-ray in the last 2 weeks? Yes No

Have you had a nuclear medicine scan or injection of an X-ray dye in the last week? Yes No

Your age: ______________ Your sex (circle): Female Male

Have you ever had a bone density test? Yes No

Where? ______________________________

Your tallest height (late teens or young adult): ______________

Your ethnicity (circle): Caucasian (white) Black Asian Hispanic Other

Do you drink alcohol? Yes No

Do you have (circle): 0-2 drinks/day 3 or more drinks/day

Did either of your parents have a broken hip? Yes No

Have you taken steroids (glucocorticoids) in the past, for more than 3 months? Yes No

Are you taking steroids (glucocorticoids) now? Yes No

Have you ever broken a bone from a minor injury? Yes No

Do you have Rheumatoid Arthritis? Yes No

Do you have any ongoing medical problems? ______________________________
(such as: Diabetes mellitus, kidney failure, liver impairment, multiple sclerosis, chronic obstructive pulmonary disease (COPD), hyperparathyroidism, hyperthyroidism, hypercortisolism, cushing's disease, anorexia nervosa, bulimia, or malabsorption syndromes such as celiac disease

Do you smoke (use tobacco products) Yes No

Have you had surgery of the spine, hips, legs, or arms? Yes No

If yes, which bone, which side? ______________________________

Do you take calcium: Yes No How much / how often? ______________

Do you take Vitamin D? Yes No How much / how often? ______________

For WOMEN only:

When was your last period? ______________ Age at menopause? ______________

Have you had a hysterectomy? Yes No

Have you had your ovaries removed? Yes No

For TECHNOLOGIST ONLY: (circle responses)

Technical limitations: NO Yes: ______________

Were sites excluded or not scanned? NO Yes: ______________

If lowest T-score -1.1 to -2.4: FRAX done FRAX not done due to: ______________

Please answer questions on the other side also

Are you currently taking or have you previously taken any of the following medications?

Prednisone (cortisone) Yes Currently / in the past? For how long? ________

Medication for seizures or epilepsy Yes Currently / in the past? For how long? ________

Medication for prostate cancer Yes Currently / in the past? For how long? ________

Medication to prevent transplant rejection Yes Currently / in the past? For how long? ________

Chemotherapy for cancer Yes Currently / in the past? For how long? ________

Name of medicine: ______________________________

Hormone therapy for cancer Yes Currently / in the past? For how long? ________

Anastrozole - (Arimidex)

Letrozole - (Femara)

Exemestane - (Aromasin)

Hormone replacement therapy (Estrogen) Yes Currently / in the past? For how long? ________

Raloxifene (Evista) Yes Currently / in the past? For how long? ________

Testosterone Yes Currently / in the past? For how long? ________

Sodium fluoride Yes Currently / in the past? For how long? ________

Teriparatide (Forteo, PTH) Yes Currently / in the past? For how long? ________

Calcitonin (Miacalcin, Fortical) Yes Currently / in the past? For how long? ________

Etidronate (Didronel/Didrocal) Yes Currently / in the past? For how long? ________

Alendronate (Fosamax) Yes Currently / in the past? For how long? ________

Risedronate (Actonel, Atelvia) Yes Currently / in the past? For how long? ________

Pamidronate (Aredia) Yes Currently / in the past? For how long? ________

Ibandronate (Boniva) Yes Currently / in the past? For how long? ________

Zoledronic acid (Zometa, Reclast) Yes Currently / in the past? For how long? ________

Denosumab (Prolia, Xgeva) Yes Currently / in the past? For how long? ________

Abaloparatide (Tymlos) Yes Currently / in the past? For how long? ________