

OSTEOPOROSIS SCREENING FORM

Technologist: _____
ID #: _____
Date: _____

Name: _____ Date of Birth: _____

Current: Height: _____ inches Weight _____ lbs Ethnicity _____ Sex: F M

Previous Dexa _____ Referring Physician: _____

In the last week have you had any barium X-Rays? _____ Nuclear Medicine? _____

1. Are you currently taking any of the following medications and for how long?

Calcium _____	Boniva _____	Estrogen _____
Vitamin D _____	Calcitonin _____	Thyroid med _____
Fosamax _____	Tamoxifen _____	Steroids _____
Evista _____	Other _____	

2. What was your maximum height? _____

3. Do you have a family history of osteoporosis? Who? _____

4. Do you have scoliosis? _____ Back fracture/surgery? _____ Hip fractures/surgery? _____

5. Do you perform weight bearing (includes walking/ treadmill, etc) exercise regularly? _____

What kind? _____ Frequency _____

6. Do you regularly include dairy and high calcium foods in your diet? _____

7. Have you ever missed your menstrual periods for more than 6 months?
(Not including menopause or pregnancy.) _____

8. Have you had your menopause? _____ @ age _____ Have your ovaries been removed? _____

9. Have you had any fractures as an adult that were not the result of serious trauma? _____
If yes, what _____

10. Do you smoke? _____ How long have you smoked? _____

11. Do you consume more than 2 alcoholic drinks daily? _____

12. Do you drink caffeinated beverages? _____ How many daily _____

13. Do you have or have had any of the following medical conditions?

Hyperthyroidism _____	Anorexia or Bulimia _____
Hyperparathyroidism _____	Inflammatory bowel disease _____
Arthritis: osteo _____ rheumatoid _____	Asthma or emphysema _____
Cancer _____	Other _____