

Weill Cornell Imaging
at NewYork-Presbyterian

Date: _____

Please answer the following questions. If you are not sure how to answer a question, please ask a staff member for assistance. All answers will be kept in strict confidence and treated as medical record information.

1. Name _____ Referring Physician _____

2. Date of Birth _____ Handedness: Right _____ Left _____

3. Height _____ Weight _____

4. Race

African American _____ Asian _____ Caucasian _____ Hispanic _____

Native American _____ Other _____

5. Sex Female _____ Male _____

6. Have you had a previous Bone Density test (DEXA)? Yes _____ No _____

When _____ Where _____

7. Have you ever been diagnosed with Osteoporosis Yes _____ No _____ or

Osteopenia Yes _____ No _____ If so, when _____

8. Have you ever been treated for osteoporosis or osteopenia? Yes _____ No _____

Are you being treated currently: Yes _____ No _____

Were you treated in the past only: Yes _____ No _____

Specify drug(s) _____ Dose: _____

Date of use: _____

9. Do you take calcium supplement daily? Yes _____ No _____

If so, how much? _____ mg/day

10. Do you currently take Fosamax? Yes _____ No _____ In the past _____

If so, how much _____; How long _____

11. Have you fractured any bones during your lifetime?

a) Spine _____ Date _____

b) Hip _____ Date _____

c) Other _____ Date _____

BONE DENSITY: PATIENT HISTORY FORM

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12. Have you had any of the following surgery?

a) Laminectomy / Fusion (lumbar spine) Date _____

b) Abdominal Surgery Date _____

c) Hip Surgery:

Fracture (right/left) Date _____

Prosthesis (Right/Left) Date _____

Hardware (ORIF) (Right/Left) Date _____

d) Thyroid/Parathyroid surgery Date _____

13. Does your family have a history of osteoporosis? Yes ___ No ___

14. Do you smoke more than half a pack of cigarettes per day? Yes ___ No ___

15. Have you smoked in the past? Yes ___ No ___ Packs per Day _____

16. Do you have 3 or more servings of dairy products every day? Yes ___ No ___

(One Serving= 8 oz. Milk, 1.5 oz. cheese, 8 oz. Yogurt, 8 oz. Cottage cheese, or 4 oz. Ice cream)

17. Do you exercise at least three times a week? Yes ___ No ___

18. Have you taken any of the following medications or treatments?

a) Steroids (prednisone, cortisone, etc.) Yes ___ No ___

b) Thyroid medication Yes ___ No ___

c) Anticonvulsants (for seizures, epilepsy) Yes ___ No ___

d) Loop diuretics (Lasix, Bumex, Edicrin) Yes ___ No ___

e) Heparin Yes ___ No ___

f) Chemotherapy Yes ___ No ___

g) Lithium Yes ___ No ___

h) Birth Control Pills Yes ___ No ___

i) Hormone Replacement Therapy Yes ___ No ___

j) Antacids Yes ___ No ___

k) Vitamins Yes ___ No ___

19. Have you had any of the following conditions?

a) Hyperthyroidism or hypothyroidism Yes ___ No ___

b) Heperparathyroidism Yes ___ No ___

c) Biliary Cirrhosis Yes ___ No ___

d) Kidney disease Yes ___ No ___

e) Rheumatoid Arthritis Yes ___ No ___

f) Other arthritis Yes ___ No ___

g) Part of stomach removed Yes ___ No ___

h) Intestinal or bowel disease Yes ___ No ___

i) Eating Disorders (anorexia nervosa, bulimia) Yes ___ No ___

BONE DENSITY: PATIENT HISTORY FORM

- j) Scoliosis Yes ___ No ___
- k) Liver disease Yes ___ No ___
- l) Seizure disorder Yes ___ No ___
- m) Increased calcium Yes ___ No ___

20. Have you had any of the following radiographic tests?

- a) Myelogram Date _____
- b) CT w/ contrast Date _____
- c) Barium study Date _____
- d) X-rays of spine Date _____
- e) X-rays of Hips Date _____
- f) Nuclear Medicine Study:
 - Scan Date _____
 - Treatment w/ radioactive Material: Date _____
 - Test w/ radioactive material: Date _____

Remaining Questions for Women Only

- 21. Is there any possibility that you are pregnant? Yes ___ No ___
- 22. What was the date of your last menstrual period _____
- 23. Have you gone through menopause? Yes ___ No ___
 - If yes:
 - A. Regular _____ Year _____ Age _____
 - or
 - B. Surgical _____ Year _____ Age _____
 - 1) Hysterectomy: (uterus removed) Yes ___ No ___
Year _____
 - 2) Ovaries removed Yes ___ No ___
Year _____
- 24. Did your menopause occur before age 45? Yes ___ No ___
If yes, what age _____
- 25. Have you ever had amenorrhea (missed periods or no periods)? Yes ___ No ___
- 26. Do you currently take hormone replacement therapy (HRT) Yes ___ No ___
If no, did you take HRT in the past? Yes ___ No ___ When _____
How many years _____
- 27. Have you had any of the following conditions?
 - a) Breast Cancer Yes ___ No ___
 - b) Cancer of the uterus Yes ___ No ___

If yes, Year diagnosed _____