SAINT LOUIS ASSOCIATES IN OB/GYN INC.
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Bone Densitometry Patient History

*Name*_____ *Date*_____/_____/_____
MM DD YYYY

*DOB*_____/_____/_____ *Sex* M F *Height*_____'_____" *Weight*_____Lbs.
MM DD YYYY

Pregnancy Status Yes No *Prior BMD Studies* Yes No *If Yes, Site*_____L or R

*Where was the last study performed*_____

Patient History:
(Please Circle Yes or No)

-*Fracture(s) as Adult* Yes No *If Yes, Site*_____ -*Cancer* Yes No *If Yes, Site*_____

-*Height Loss* Yes No -*Milk Allergy* Yes No

-*Lupus* Yes No -*Scoliosis* Yes No

-*Asthma* Yes No -*Hip or Back Surgery* Yes No

-*Use of Inhaler* Yes No If Yes, PRN or Regular

-*Sprue/Celiac Disease* Yes No -*DJD/Arthritis* Yes No

-*Smoker* Yes No *If Yes, How Long*_____Yrs. *Packs/Day*_____
Quit for _____Yrs.

-*Consume More Than 2 Alcoholic Drinks Per Day* Yes No

-*Family History of Osteoporosis* Yes No *If Yes, Relationship*_____

-*Any Known or Diagnosed Diseases at Present* Yes No *If Yes, Explain*_____

-*Post Menopausal* Yes No *If Yes, What Age Did Menopause Begin*_____

-*Hysterectomy* Yes No *If Yes:* Partial or Complete *Year*_____

-*Hormone Replacement Therapy* Yes No *# of Years*_____ *Discontinued Use*_____

Medications:
Previous Treatment for Osteoporosis Yes No *If Yes, Drug Prescribed*_____
*Calcium*_____ *Duration*_____
*Vitamin D*_____ *Duration*_____
*Thyroid*_____ *Duration*_____
*Corticosteroids*_____ *Duration*_____