Physicians for Women of Greensboro

Patient History Sheet

Bone Densitometry

Name	DOB	PT ID

Please circle Yes or No to the following questions

Is there any family history of osteoporosis?	Yes	No	
Do you smoke?	Yes	No	If yes, how long? _____
Have your menstrual periods stopped?	Yes	No	If yes, when? _____
Have you had a hysterectomy?	Yes	No	If yes, when? _____
Have you had your ovaries removed?	Yes	No	If yes, when? _____
Are you taking hormones?	Yes	No	If yes, how long? _____
Do you avoid dairy products?	Yes	No	
Do you take calcium supplements?	Yes	No	If yes, Milligrams/day _____

What was you tallest height (late teens or early adult)? Ft. Inches

Have you ever had…

Thyroid condition requiring medication?	Yes	No
Epilepsy?	Yes	No
Rheumatory arthritis?	Yes	No
Cancer?	Yes	No
Chemotherapy or radiation therapy?	Yes	No

Have you ever broken a bone from a simple fall?	Yes	No	If yes, which bone?____
Have you ever had a previous bone density exam?	Yes	No	If yes, when? _____ where?_____

Have you ever had surgery on your back?	Yes	No
Have you ever had surgery on either hip?	Yes	No

List all medications you are currently taking:

Patient Signature Date