

HIRSCH & RATAKONDA, M.D., P.A.

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Bone Densitometry Study

Date: _____

MR#: _____

Please complete the following questions to the best of your ability. If you are unclear what to answer, leave the space blank and the technician will help you when you are seen. All information will be make part of your medical records and kept in strict confidence.

Name: _____

Sex: **(circle one)** Female Male

Age: _____ Height: _____ Weight: _____

Race: **(circle one)** White Black Asian Hispanic Other

Why are you having this test?: _____

Have you fractured any bones as an adult?: yes no Have you had this test before?: yes no

Any family history of osteoporosis?:..... Yes No

Do you take calcium supplement daily?:..... Yes No

(If so, how much?): 0-500mg/day 501-1000mg/day 1000mg+/day

Are you on a prescriptive bone loss therapy?:..... Yes No

(If yes, what?): _____

Have you taken any of the following medications?:

- Steroids (prednisone, cortisone, etc.)..... Yes No
- Thyroid medication..... Yes No
- Anti-convulsants (for seizures, epilepsy)..... Yes No

For Women Only:

- Breast Cancer?:..... Yes No
- Have you had breast cancer preventative therapy?:..... Yes No
- Did your menstrual cycle never begin or have minimal periods?:..... Yes No
- Are you now on hormone replacement (Premarin, Estrogen, etc.):..... Yes No
- Have you taken hormones in the past? **(not including birth control)**:..... Yes No
- Are you post menopausal?:..... Yes No

(If yes, at what age?): _____

ALL PATIENTS PLEASE ANSWER THE FOLLOWING QUESTION TO THE BEST OF YOUR ABILITY.

IF IN DOUBT ANSWER NO:

As an adult have you had a spontaneously occurring fracture or a fracture from trauma that may not have occurred in a healthy individual?:..... Yes No

Have a parent who suffered a fractured hip?:..... Yes No

Do you currently smoke tobacco?:..... Yes No

Have you taken oral glucocorticoids (such as prednisone, etc.) at a dose of 5mg for a period of 3 or more months?:..... Yes No

Do you have a confirmed diagnosis of rheumatoid arthritis?:..... Yes No

Do you have a history of any disorder listed below?:..... Yes No

- Type 1 diabetes
- Osteogenesis imperfecta as an adult
- Untreated hyperthyroid
- Hypogonadism/menopause prior to age 45
- Chronic malnutrition or malabsorption conditions
- Chronic liver disease

Do you consume 3 or more alcoholic beverages daily?:..... Yes No