SPRING HILL
IMAGING CENTER

Patient History Form

Name: ____________________ Todays Date: __________
Patient ID: ____________________ Sex: M F
Current Height: ____________________ Date of Birth: __________
Weight: ____________________ Referring Dr: ____________________
Menopause Age: ____________________ Ethnicity: ____________________

1. Have you had a previous hip or vertebral fracture? Yes [ ] No [ ]
2. Have you had any fractures during your adult life which did not result from a significant trauma (e.g. auto accident)? Yes [ ] No [ ]
3. Did either of your parents ever have a hip fracture? Yes [ ] No [ ]
4. Do you smoke? Yes [ ] No [ ]
5. Have you ever taken Glucocoticoids? Yes [ ] No [ ]
6. Do you have rheumatoid arthritis? Yes [ ] No [ ]
7. Do you have secondary osteoporosis? Yes [ ] No [ ]
8. Do you drink 3 or more alcoholic drinks per day? Yes [ ] No [ ]
9. Are you being treated for osteoporosis? Yes [ ] No [ ]
10. Have you ever taken any of the following medications:

Actonel (i.e. risedronate)	Yes [ ]	No [ ]	Boniva (i.e. ibandronate)	Yes [ ]	No [ ]
Evista (i.e. raloxifene)	Yes [ ]	No [ ]	Forteo (i.e. parathyroid hormone)	Yes [ ]	No [ ]
Fosamax (i.e. alendronate)	Yes [ ]	No [ ]	HRT (i.e. estrogen/hormone therapy)	Yes [ ]	No [ ]
Miacalcin (i.e. calcitonin)	Yes [ ]	No [ ]	Protelos (i.e. strontium ranelate)	Yes [ ]	No [ ]
Reclast (i.e. zoledronate)	Yes [ ]	No [ ]	Prolia (i.e. denosumab)	Yes [ ]	No [ ]
Vitamin D	Yes [ ]	No [ ]	Calcium	Yes [ ]	No [ ]

Other - Please specify: ____

11. Do you have any of the following medical conditions:

Anorexia or Bulimia	Yes [ ]	No [ ]	Any seizure disorders	Yes [ ]	No [ ]
Asthma or Emphysema	Yes [ ]	No [ ]	Cancer	Yes [ ]	No [ ]
End stage renal disease	Yes [ ]	No [ ]	Inflammatory bowel disease	Yes [ ]	No [ ]
Hyperparathyroidism	Yes [ ]	No [ ]	Hysterectomy	Yes [ ]	No [ ]

Other - Please specify: ____

12. What was your maximum height (inches)? __________
13. Do you perform weight bearing exercise regularly? Yes [ ] No [ ]
14. Do you regularly consume dairy products? Yes [ ] No [ ]
15. Do you drink beverages containing caffeine? Yes [ ] No [ ]

If Female

16. At what age did your period start? __________
17. Are you premenopausal? Yes [ ] No [ ]
18. How many full-term pregnancies have you had? __________
19. Have you ever missed your period for more than 6 months in a row? (not including pregnancy or menopause)? Yes [ ] No [ ]