

# Oklahoma Breast Care Center Bone Density Screening

**PLEASE PRINT**



FILE #	DATE	APPT. TIME			COMPUTER #
PATIENT'S NAME: Last		First	MI	Social Security Number	Date of Birth
ADDRESS: Street or P.O. Box			City	State	Zip Code
AGE: <input style="width: 40px; height: 20px;" type="text"/>	Physician Full Name		How did you hear about us?	Home Phone #	
EMPLOYER:				Work Phone #	
INSURANCE COMPANY NAME:			Insured's Name		
INSURANCE: ID Number			Group or Plan Number		

## Patient History

Height: _____	Race:	White	Black	Asian	Other		
Weight: _____						YES	NO
1 Do you have a family history of osteoporosis? _____							
2 Do you exercise? _____							
3 Have you had a hysterectomy? _____ L.M.P.							
4 Were your ovaries removed? _____							
5 Are you a post menopausal woman? _____							
If yes, when did you start menopause? _____							
6 Have you ever had a fracture on your back, hip or wrist as an adult? _____							
If yes, when? _____							
7 Have you ever had surgery on your back, hip or wrist as an adult? _____							
If yes, when? _____							
8 Have you lost more than 2 inches of height since high school? _____							
9 Do you take hormones? _____							
10 Do you take thyroid medication regularly? _____							
11 Do you have hyperparathyroidism? _____							
12 Do you have hyperthyroidism? _____ If yes, how long?							
13 Have you had an x-ray exam in the last week? _____							
If yes, what kind? _____							

**Do you have any of the following conditions?**

	YES	NO
Low calcium or Vitamin D intake _____		
Rheumatoid Arthritis _____		
Cushing's Syndrome _____		
Malabsorption Syndrome _____		
Anorexia Nervosa or other Eating Disorder _____		
Inflammatory Bowel Disease _____		
Multiple Myeloma _____		
Chronic Renal Failure _____		
Ovarian or Testicular Hypofunction _____		
Personal or Family History of Breast Cancer _____		
Do you smoke _____		
Do you drink alcohol _____		

**Are you taking any of these drugs?**

	YES	NO
Phenytoin (for seizures) _____		
Heparin _____		
Thyroxine (Thyroid Replacement) _____		
Large Amounts of Caffeine _____		
Long Term Steroid Use _____		

**Are you taking any of these to treat or prevent osteoporosis?**

	YES	NO
Vitamin D _____		
Calcium Supplements _____		
Fosamax (Alendronate) _____		
Raloxifene (Evista) _____		
Calcitonin _____		
Didronel (Etidronate) _____		
Other _____		

\* I am aware that effective April 14, 2003 I have access to the Patient's Privacy Notice enforced by Oklahoma Breast Care Center upon request.

\_\_\_\_\_  
Patient or Guardian Signature                      Date

**Technologist Comments:**

Baseline \_\_\_\_\_ Compare \_\_\_\_\_ Tech \_\_\_\_\_