Bone Density Assessment

for MALES

Appointment Date: ____/____/______ Time: _____ : _______ (AM/PM) Date of Birth: ____/____/______

Patient Name: ____

Account Number: ______________________ Weight: ________ Height: ____________

Race: ☐ African-American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Other

Reason for Test: ____

Referring Physician: ____

Yes	No	
☐	☐	Have you had a previous bone density exam?
☐	☐	Have you had hip surgery?
☐	☐	Have you had lumbar spine surgery?
☐	☐	Since the age of 20, have you broken a bone? If yes, what have you broken? ______________________
☐	☐	Do you have a family history of osteoporosis? What relation to you? ______________________
☐	☐	Has anyone in your family had a hip fracture as an older adult?
☐	☐	Do you smoke cigarettes?
☐	☐	Have you smoked in the past? When did you quit? ______________
☐	☐	Do you drink alcohol? If yes, how many drinks daily? __________

Medications
(check all that apply)

- ☐ Calcium/Vitamin D
  _____mg _____times/day
- ☐ Multi-vitamin
- ☐ Fosamax
- ☐ Actonel
- ☐ Boniva
- ☐ Miacalcin nose spray
- ☐ Reclast infusion
- ☐ Prednisone
- ☐ Seizure medication
- ☐ Thyroid medication
- ☐ Inhaled steroids

Additional medical history
(check all that apply)

- ☐ Prostate cancer
- ☐ Rheumatoid arthritis
- ☐ Thyroid disease
- ☐ Kidney stones
- ☐ Dialysis

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