PATIENT #:
AGE:

ARLENE M. WEINSHELBAUM, M.D.
PATIENT HISTORY FOR BONE DENSITOMETRY

Name ______________________________

Address ______________________________

City, State, Zip ______________________________

Date of Birth ______________ Sex ____ Height ________ Weight ______

Referring Physician ______________________________

Please list any other doctors you want to receive a report ______________

	Yes	No
Have you ever been diagnosed with osteoporosis?	____	____
Do you have a family history of osteoporosis?	____	____
Have you lost any height?	____	____
Do you have a thin, small build?	____	____
Do you have a sedentary lifestyle?	____	____
Have you taken any of the following medications?		
a. Steroids (prednisone, cortisone, etc.) long term	____	____
b. Thyroid medication	____	____
c. Anti-convulsants (for seizures, epilepsy)	____	____
Have you had any of the following conditions?		
a. Hyperthyroidism (over-active thyroid)	____	____
b. Low back pain	____	____
c. Rheumatoid arthritis	____	____
d. Other arthritis	____	____
Do you take a calcium supplement daily?	____	____

If so, how much? ______________________________

Have you had any stress fractures not related to accident/trauma? ______________

For Women Only:

Have you gone through menopause (change of life)? ______________

If yes, did your menopause occur before age 45? ______________

Do you now take hormones? (Premarin, estrogen, etc)? ______________

Have you had any of the following conditions?	**Yes**	**No**
a. Hysterectomy	____	____
b. Ovaries removed	____	____