The Women's Health Center
Denville, Dover, Parsippany, and Sussex

Name:____ **Age**_____ **Date of Birth**_______________

Referring physician: _________________________ **Today's date**______________________________

Ethnicity: Black ____ Caucasian ____ Asian____ Hispanic____ Other____

Weight__________ **Height**_______ **LMP**_________ **Are you pregnant?** Yes____ No ____

Did you have any radiology contrast studies or nuclear medicine test this week? Yes____ No____

Have you ever had a Bone Density test? Yes____ No____

Have you ever been diagnosed with bone loss or Osteoporosis? Yes____ No____

If yes, type of treatment: _________________________ **# of years on treatment:** ____________

Please list all prescription medications: ____

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Family history of Osteoporosis? Yes____ No____ **Personal history of cancer?** Yes____ No____

If yes, what type?__________________ **Treatment:** __Chemotherapy __Hormone therapy __Radiation

Have you had any history of adult bone fractures? (broken bones) Yes____ No____ Where?________

Please check any that pertain to you:

____Post Menopausal: What Age____
____PeriMenopausal
____Hormone Replacement
____Hysterectomy ___w/ovaries removed
____Amenorrhea (no longer menstruating)
____Hypothyroidism
____Hyperparathyroidism
____Cushing's Syndrome
____Renal Failure (Kidney Problems)
____Other (please explain)______________________

____Height Loss
____Low Calcium
____Low Body Weight
____Hypocalcemia (Low Calcium)
____Osteoarthritis
____Rheumatoid Arthritis
____Anticonvulsants (Seizure Medication)
____Steroid Use (Long Term)
____Tobacco Use
____Alcohol use (3 or more drinks per day)

Patient Signature: ____Date:_________Time:______

Technologist Signature:____Date:_________Time:______