Appt. date/time

No Calcium pills 24 hours prior to scan
No Metal on Clothes

Deschutes Rheumatology

Name	Account #	Birthdate Age Sex
Street	Height	Referring Physician
City, State, Zip	Weight	Primary Physician
Phone ( )	Tallest Height	Today's Date

Have you had this test before? ❑ Yes ❑ No If yes, when?

In the past two weeks, have you had any x-ray studies: Contrast agent/dye?	Date

Have you ever had any of the following fractures?	Yes	Date
Pelvis Fracture		
Vertebral (spine) Fracture		
Arm Fracture		
Leg Fracture		
Other Fracture(s) (explain):		

List all Surgical Procedures	Year	List all Surgical Procedures	Year
1.		4.	
2.		5.	
3.		6.	

Ancestry: ❑ White ❑ Native American ❑ Black ❑ Asian ❑ Hispanic

Do you have a relative with height loss? ❑ Yes ❑ No Fractures of the spine or hip? ❑ Yes ❑ No

Has either parent had a hip fracture? ❑ Yes ❑ No

Have you ever smoked? ❑ Yes ❑ No Number of Packs per Day: _____ Number of Years: _____

Have you ceased smoking? ❑ Yes ❑ No If yes, how long ago? _____

Do you drink alcohol? ❑ Yes ❑ No Number of Drinks per Day: _____ Drinks per Week: _____

Do you drink caffeinated coffee, tea or colas? ❑ Yes ❑ No Number of Cups per Day: _____ Number of Years: _____

Do you avoid milk, dairy products? ❑ Yes ❑ No If yes, how long? _____

Chronic long-term need for Cortisone/Prednisone? ❑ Yes ❑ No If yes, how long? _____

Exercise history: ❑ Minimal ❑ Moderate ❑ Vigorous What type? _____

List all medication (name, dose, frequency, number of months/years):

Name	Dose	Frequency	#Months/ Years	Name	Dose	Frequency	#Months/ Years

Do you take calcium? ❑ Yes ❑ No Dosage _____

Do you take Vitamin D? ❑ Yes ❑ No Dosage _____

Do you take Multi Vitamins? ❑ Yes ❑ No Dosage _____

Please check specific diseases you have or have had:

❑ Rheumatoid Arthritis
❑ Chronic Diarrhea
❑ Malabsorption
❑ Kidney Stones
❑ Hyperthyroidism
❑ Diabetes
❑ Hyperparathyroidism
❑ Epilepsy, Seizures
❑ Liver Disease
❑ Pituitary Disease
❑ Eating Disorder
❑ Cortisone/Prednisone Use
❑ Amenorrhea (no menstrual periods)
❑ Illness with bed rest (more than one month)
❑ Other _____

For Women Only

Do you now, or have you previously taken Estrogen? ❑ Yes ❑ No When started? _____ When stopped? _____ Dosage? _____

Have you had menopausal symptoms (hot flashes, mood swings, night sweats)? ❑ Yes ❑ No Age ____

Have your ovaries been removed? ❑ Yes ❑ No If yes, when (date): _____