



# MANA Health Services Osteoporosis Testing Center

Patient Name: \_\_\_\_\_ Chart Number: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Have you had previous densitometry? \_\_\_\_\_

If yes, list date and location: \_\_\_\_\_

Family history of osteoporosis? Yes \_\_\_ No \_\_\_ Unknown \_\_\_ If yes, who? \_\_\_\_\_

Age of menopause (female only) \_\_\_\_\_

Are you currently taking hormones (female only)? Yes \_\_\_ No \_\_\_

Name of hormone and dose:  
\_\_\_\_\_

List years of any hormone use and when you quit: \_\_\_\_\_

Calcium intake: Milk: \_\_\_\_\_ ounces per day

Calcium tablet: Name \_\_\_\_\_ Milligrams per day \_\_\_\_\_

Do you take Prednisone? Yes \_\_\_ No \_\_\_

List any previous bone fractures and when: \_\_\_\_\_

Did any fractures occur with a fall from a standing height or less? Yes \_\_\_ No \_\_\_

If yes, which fracture?  
\_\_\_\_\_

## **PERTINENT SURGERIES**

Hysterectomy (female) \_\_\_\_\_ Ovaries removed? Yes \_\_\_ No \_\_\_

Spine surgery or metal inserted in spine: \_\_\_\_\_

Hip replacement: \_\_\_\_\_

(NEXT PAGE)

Patient Name: \_\_\_\_\_

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**MEDICATIONS**

	<u>Dose you take</u>	<u>Years of use</u>
Evista	_____	_____
Actonel	_____	_____
Fosamax	_____	_____
Forteo	_____	_____
Miacalcin	_____	_____
Testosterone (male only)	_____	_____

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**CURRENT MEDICAL CONDITIONS**

Cigarette Use: Yes \_\_\_\_\_ No \_\_\_\_\_

Packs per day \_\_\_\_\_

Renal Failure \_\_\_\_\_ Dialysis \_\_\_\_\_ Renal Transplant \_\_\_\_\_

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