



ARTHRITIS CARE CENTER, PC

COMPLETE RHEUMATOLOGY CARE

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BONE DENSITY PATIENT HISTORY

Reason for exam: _____

Referring Physician: _____

Primary Care Physician: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____

Race (Circle one): **Black** **White** **Asian** **Hispanic** **Other**

Have you experienced height loss? **Y** **N** If so, how much? _____

Do you have low back pain? **Y** **N** How would you classify it? **Chronic/Acute/Severe**

Have you had a hip pinning, replacement, or plate? **Y** **N** Which hip? **Right** **Left**

Have you fractured any bones since turning 30? **Y** **N**

Which ones? _____

Does anyone in your family have osteoporosis? **Y** **N**

Who? _____

Have you had of anorexia or nutritional deficiency? **Y** **N**

Explain: _____

Do you smoke more than ½ pack of cigarettes a day? **Y** **N**

Do you have more than 2 alcoholic drinks daily? **Y** **N**

How many dairy servings do you consume daily? _____

Have you done this most of your life? **Y** **N**

Do you take calcium supplements daily? **Y** **N** How much? _____mg daily

Do you exercise at least 3 times per week? **Y** **N**

Have you ever taken following medications: Steroids (prednisone, cortisone, etc.)? **Y** **N**

Thyroid medications? **Y** **N**

Anti-Seizure or epilepsy medication? **Y** **N**

Sleeping pills? **Y** **N**

Circle the osteoporosis medications you take, if any: **Fosamax, Fosamax-D, Actonel, Actonel w/calcium, Evista, Miacalcin, Forteo, oral Boniva, IV Boniva**

Please list ALL your medications _____

Have you ever experienced:	Partial or complete paralysis?	Y	N
	Over- active thyroid?	Y	N
	Kidney disease?	Y	N
	Rheumatoid Arthritis?	Y	N
	Part of your stomach removed?	Y	N
	Intestinal or bowel disease?	Y	N
	G.I. complications (ulcers, acid reflux)?	Y	N

FOR OFFICE USE: Height _____ Weight _____ MRN _____

FEMALE HISTORY QUESTIONS

Is there a possibility that you may be pregnant?	Y	N	
At what age did your periods start?	_____		
Have you gone through menopause?	Y	N	At what age? _____
Did your menopause occur before age 45?	Y	N	

Have you had any of the following conditions?

Hysterectomy (womb removed)?	Y	N
Ovaries removed?	Y	N
Blood clots?	Y	N

If you answered yes to any of the above, were you on hormones at the time? Y N

Have you had any of the following:

Breast Cancer?	Y	N
Family history of Breast Cancer?	Y	N
Cancer of the Uterus (womb)?	Y	N

Have you ever taken hormones (besides birth control pills)? Y N

For how long? _____ years.
 Are you taking hormones now? Y N Which ones? _____

If you answered yes to the above hormone questions, please answer the following:

Have you suffered any of the following side effects from hormones:

Breast soreness?	Y	N
Heavy periods or other bleeding?	Y	N
Headaches?	Y	N
Weight gain or fluid buildup?	Y	N
Other:	_____	