Mankato Clinic

(Patient sticker)

Patient History

In the past 2 weeks, have you had any of the following?

- Barium x-ray / Nuclear Medicine scan / CT scan with oral contrast? ☐ Yes ☐ No

In the past 2 days, have you had a CT scan or MRI with IV contrast? ☐ Yes ☐ No

Race (*circle*): Caucasian(white) Black Asian Hispanic Native American
Other_____

Current Weight _____ Current Height _____ Height at age 20 _____

Are you postmenopausal (no longer having periods)? ☐ Yes ☐ No If yes, what age_____

Prior hysterectomy that included removal of both ovaries? ☐ Yes ☐ No ☐ N/A If yes, age _____

Are you currently or have you ever been treated with any of the medications listed at the right (*check which medications, if any*)? **If yes, please note approximate years taken (example, 1997-2000).**

☐ Estrogen Replacement (Premarin) _____
☐ Raloxifene (Evista)_____
☐ Alendronate (Binosto, Fosamax) _____
☐ Risedronate (Actonel, Atelvia) _____
☐ Teriparatide (Forteo, PTH) _____
☐ Calcitonin (Miacalcin, Fortical) _____
☐ Ibandronate (Boniva) _____
☐ Zoledronic acid (Reclast, Zometa) _____
☐ Denosumab (Prolia,Xgeva) _____
☐ Abaliparatide (Tymlos) _____
☐ Romosozumab (Evenity) _____

Do you take calcium supplements (including antacids)? ☐ Yes ☐ No How long? _____

Do you take Vitamin D or multivitamins? ☐ Yes ☐ No How long? _____

Have you taken oral prednisone or cortisone? ☐ Yes ☐ No When? _____

If yes, what dose and for how long? _____

CONTINUE ON BACK

Do you have a history of any of the following (*please check if yes*)?

☐ Celiac disease
☐ Crohn's Disease
☐ Hyperparathyroidism /elevated blood calcium level?
☐ Seizures/Epilepsy requiring oral medications
☐ Weight reduction surgery
☐ Intestinal bypass surgery
☐ Chemotherapy
☐ Cancer (*type and when*) _____
☐ Cancer of the prostate treated with hormone therapy/orchiectomy
☐ Anorexia / Bulimia
☐ Ulcerative colitis
☐ Hyperthyroidism

Please give brief details of any checked items above _____

_____

_____

Do you have a history of smoking?	☐ Yes	☐ No	How long? _____
Family history of parent/sibling/child hip fracture?	☐ Yes	☐ No	
Do you have a confirmed diagnosis of Rheumatoid Arthritis?	☐ Yes	☐ No	
Do you have insulin dependent diabetes (Type 1)?	☐ Yes	☐ No	
Do you have untreated long term hyperthyroidism?	☐ Yes	☐ No	
Do you have chronic liver disease? (ie: Cirrhosis, fibrosis)	☐ Yes	☐ No	
Do you have history of malnutrition or malabsorption?	☐ Yes	☐ No	
Do you consume 3 or more drinks per day of Alcohol?	☐ Yes	☐ No	
Do you have a hip replacement?	☐ Yes	☐ No	Which side? _____
Have you had lower back surgery?	☐ Yes	☐ No	

Do you have a history of "low trauma?"
Broken bones as an adult
(Such as from a simple fall – standing height or less)? ☐ Yes ☐ No
If yes, which bone(s)? _____

Have you ever had a bone density test? ☐ Yes ☐ No
If yes, where and when? _____