

NEW CENTURY IMAGING
555 KINDERKAMACK RD, ORADELL, NJ 07649
(201)599-1311

PATIENT HISTORY QUESTIONNAIRE

Name:	<input type="text"/>	Today's Date:	<input type="text"/>
Patient ID:	<input type="text"/>	Sex:	<input type="radio"/> F <input type="radio"/> M
Current Height: (in)	<input type="text"/>	Date of Birth :	<input type="text"/>
Weight: (lb)	<input type="text"/>	Referring Physician:	<input type="text"/>
Menopause Age:	<input type="text"/>	Ethnicity:	<input type="text"/>

- 1. Have you had a previous hip or vertebral fracture? Yes No
- 2. Have you had any fractures during your adult life which did not result from significant trauma (e.g., auto accident)? Yes No
- 3. Did either of your parents ever have a hip fracture? Yes No
- 4. Do you smoke? Yes No
- 5. Have you ever taken Glucocorticoids? Yes No
- 6. Do you have rheumatoid arthritis? Yes No
- 7. Do you have secondary osteoporosis? Yes No
- 8. Do you drink 3 or more alcoholic drinks per day? Yes No
- 9. Are you being treated for osteoporosis? Yes No

10. Have you ever taken any of the following medications:
- | | |
|---|--|
| <input type="checkbox"/> Actonel (i.e. risedronate) | <input type="checkbox"/> Boniva (i.e. ibandronate) |
| <input type="checkbox"/> Evista (i.e. raloxifene) | <input type="checkbox"/> Forteo (i.e. parathyroid hormone) |
| <input type="checkbox"/> Fosamax (i.e. alendronate) | <input type="checkbox"/> HRT (i.e. estrogen/hormone therapy) |
| <input type="checkbox"/> Miacalcin (i.e. calcitonin) | <input type="checkbox"/> Protelos (i.e. strontium ranelate) |
| <input type="checkbox"/> Reclast (i.e. zoledronate) | <input type="checkbox"/> Prolia (i.e. denosumab) |
| <input type="checkbox"/> Vitamin D | <input type="checkbox"/> Calcium |
| <input type="checkbox"/> Other - Please specify: <input type="text"/> | |

11. Do you have any of the following medical conditions:
- | | |
|---|--|
| <input type="checkbox"/> Anorexia or Bulimia | <input type="checkbox"/> Any Seizure Disorders |
| <input type="checkbox"/> Asthma or Emphysema | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> End stage renal disease | <input type="checkbox"/> Inflammatory bowel diseases |
| <input type="checkbox"/> Hyperparathyroidism | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Other - Please specify: <input type="text"/> | |

- 12. What was your maximum height (inches)?
- 13. Do you perform weight bearing exercise regularly? Yes No
- 14. Do you regularly consume dairy products? Yes No
- 15. Do you drink caffeinated beverages? Yes No

- If female:
- 16. At what age did your period start?
 - 17. Are you premenopausal? Yes No
 - 18. How many full term pregnancies have you had?
 - 19. Have you ever missed your period for more than 6 months in a row (not including pregnancy or menopause)? Yes No