David Korman, M.D.
Kathleen Srock, M.D.
4500 East 9th Avenue Suite 500S
Denver, Co 80220
303 861 2190

IF IT HAS NOT BEEN 2 YEARS SINCE YOUR LAST BONE DENSITY, WE WILL NOT BE ABLE TO DO THE BONE DENSITY

PLEASE FOLLOW THESE INSTRUCTIONS FOR THE BONE DENSITY EXAM:

- **Do not take any calcium supplement or multi-vitamin, TUMS, vitamin D or ANY supplements 24 hours before your bone density. If you take calcium and/or a multi-vitamin we will reschedule your bone density because it may alter the results of your bone density.**
- You will be changing into a gown for the bone density exam
- Do not have any procedure involving IV contrast dye two weeks prior to the bone density test
- Do not have any procedure involving barium 72 hours prior to the bone density. Example: Barium swallow.
- Any body jewelry in the naval area will need to be removed
- Avoid undergarments that have glitter or metal on them
- Avoid lotions that contain glitter the day of exam
- Bracelets, watches or long necklaces will need to be removed for the test.
- Please bring the **COMPLETED** bone density questionnaire with you to your appointment
- Bring a complete medication list including the name of the medication(s), the mg, and how often you are taking the medication(s)
- If you want a copy of the results to be faxed to another physician, please bring with you: the completed physician name, address, phone number and fax number of the to your appointment
- **Please do not bring children to the exam, if for some reason you must bring your child (ren), THEY ARE NOT ALLOWED IN THE BONE DENSITY ROOM DURING THE BONE DENSITY EXAM AND MUST REMAIN IN THE WAITING ROOM. NO EXCEPTIONS!!!! This is for the safety of your child (ren).**
- Allow up to one hour for the bone density. If you have an appointment with the physician following the bone density, please allow additional time for this appointment.

Thank you

BONE DENSITY QUESTIONAIRE

Patient's name:_____ **Date of Birth**_____ **Date:**_____

Is there a chance that you are pregnant?	**YES**	**NO**
Have you had a barium x-ray in the last 2 weeks?	**YES**	**NO**
Have you had a nuclear scan or injection of an x-ray dye in the last week?	**YES**	**NO**
Have you taken your calcium in the last 24 hours?	**YES**	**NO**
Do you have hyperparathyroidism or high calcium level in your blood?	**YES**	**NO**

If you have answered YES to any of the above questions, speak to the dexa tech ASAP.

Have you had a yearly Influenza (Flu shot) vaccine?	**YES**	**NO**
Have you ever had a pneumonia shot? When?_____	**YES**	**NO**
Have you had a shingles vaccine? When?_____	**YES**	**NO**

Your age:_____ **Sex: Male Female** **Are you: left handed or right handed**

Your ethnicity: Caucasian (white) Black Asian Hispanic other:_____

Who is the physician that referred you to our practice?_____

Have you ever had a bone density? YES NO
If yes, when and where?_____

Have you had a recent weight change? YES NO
If yes, tell us about it _____

Your tallest height (late teens or young adult): _____

Have you ever broken a bone? YES NO ****

Which bone?	Simple fall?	If not a simple fall, please describe the circumstances	Age when it occurred?

Has your mother or father had a fractured hip from a simple fall from a standing height? YES NO ****

Has your mother or father had a diagnosis of osteoporosis? YES NO ****

Do you have a diagnosis from a physician of rheumatoid arthritis? YES NO ****

How many times have you fallen in the past year? _____

Have you ever had surgery on your spine, hips, legs, or arms? YES NO
If yes, please describe what kind of surgery and which side was affected

_____

_____

List any chronic medical conditions that you have:

_____

_____

List any medications that have been prescribed you. Please include the name(s) of the medication, dosage, how often you take the medication(s).

_____

_____

Name_____Date of Birth_____

Are you currently receiving, or have you previously received any of the following medications?

	NO	YES	FOR HOW LONG?
Medication for seizures or epilepsy			
Chemotherapy for cancer			
Medication to prevent organ transplant rejection			
Medication for prostate cancer			

Have you been treated with any of the following medications?

MEDICATION	
Hormone replacement therapy	
Actonel (risedronate)	
Aredia (pamidronate)	
Boniva (ibandronate sodium)	
Didronel /Didrocal (etidronate)	
Evenity	
Evista (raloxifene)	
Fluotic (sodium fluoride)	
Forteo (PTH)	
Fosamax (alendronate)	
Miacalcin nasal spray (calcitonin)	
Ostac (clondronate)	
Prolia	
Reclast (zoledronic acid)	
Steroids (Medrol/Prednisone)	
Tamoxifen	
Testosterone	
Tymlos	
Xgera	
Zometa (zoledronic acid)	

How many servings of the following do you eat or drink daily (on average)?

	Milk	Orange juice fortified with calcium	Yogurt (1/2 cup)	Cheese
Number of servings				

Do you take calcium supplements (including Tums)? YES NO How many milligrams? _____

Do you take a vitamin D supplements (including multi-vitamins and halibut liver oil) YES NO
How many IU's _____

Do you exercise regularly? YES NO daily weekly, how many times _____

What kind of exercise do you do? _____

Do you smoke tobacco currently? YES NO _____ packs/day ***

How many servings of caffeine do you have daily? _____cups/day

Do you drink alcohol? YES NO How much? _____ daily weekly monthly yearly ***

Do you have a history of eating disorders (s), including anorexia, bulimia or malabsorption? YES NO

FOR WOMEN ONLY ...

Are you still having your menstrual period? YES NO
Have you had a hysterectomy? YES NO At what age?_____
Have you had both of your ovaries removed? YES NO At what age? _____
Have you gone through menopause? YES NO At what age? _____, natural surgical
Before menopause, did you ever miss your period for more then 6 months except for pregnancy? YES NO