

23929 McBean Pkwy, Ste. #109 Valencia, CA 91355

Telephone: 661.753.5400 Fax: 661.753.5401

Name:			_ Height;' Weight:lbs
Have you entered Menopause?	☐ Yes	□No	If Yes, what age?
Have you had a Hysterectomy?	☐ Yes	□No	
Were your Ovaries removed?	☐ Yes	 □ No	If Yes, One Both
Are you taking Osteoporosis medication?	☐ Yes	□No	Name of Medication:
Are you taking Hormone replacements?	Yes	No	(premarian, estrogens etc.)
Do you have a history of Cancer?	☐ Yes	□No	
Are you taking Oral Steroids?	— □ Yes	— □ No	How long?
,	_		(longer than 3 months
Do you smoke Cigarettes?	☐ Yes	□No	How much per day?
Do you drink Alcohol?	☐ Yes	□No	If yes, how much per day?
Family history of Osteoporosis?	☐ Yes	□No	If Yes, who?
Adult Compression Spine Fractures?	☐ Yes	□No	
Any previous Adult Hip			
Fractures / Replacements?	☐ Yes	□No	If Yes, which side: O Right O Left
Did your Mother or Father			
have a Hip Fracture?	Yes	□No	O Mother O Father
Do you have a confirmed diagnosis			
of Rheumatoid Arthritis?	☐ Yes	□No	
Do you have any of the following disorder ☐ Type 1 Diabetes ☐ Osteogenes ☐ Hypogonadism ☐ Premature Model ☐ Chronic Liver Disease ☐ Chronic Male In the last week have you had: ☐ Nuclear medicine exam ☐ Contrast-medicine exam ☐ Cat Scan	is Imperfe Menopaus Inutrition	ecta e (less tha	Hyperthyroidism
Technologist Notes:			