



Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Heath Card #: \_\_\_\_\_ VC: \_\_\_\_\_

Clinical Information:

Patient's height? \_\_\_\_\_ Feet \_\_\_\_\_ inches Weight? \_\_\_\_\_ pounds

- 1. Previous Bone Density exam here or elsewhere in Ontario? If yes when? \_\_\_\_\_ Yes  No
- 2. Surgery on your lower spine or your hips? Yes  No
- 3. Nuclear medicine test or x-ray/CT with contrast (i.e. barium) in the last 2 weeks? Yes  No
- 4. Do you smoke, or have you ever smoked? If yes, for how long? \_\_\_\_\_ years Yes  No
- 5. Do you take calcium supplements (including tums)? \_\_\_\_\_ mgs How long? \_\_\_\_\_ Yes  No
- 6. Are you taking or have you ever taken (Please circle any that apply) Yes  No 
  - FOSAMAX- How long? \_\_\_\_\_ DIDROCAL- How long? \_\_\_\_\_
  - EVISTA- How long? \_\_\_\_\_ ACTONEL- How long? \_\_\_\_\_
  - PROLIA- How long? \_\_\_\_\_ ACLASTA- How long? \_\_\_\_\_
- 7. Have you been on Prednisone or steroids for more than 3 months in 1 year? Yes  No 
  - If yes, is the amount you took 2.5 mg or more in 1 day? \_\_\_\_\_ mg
- 8. Do you take thyroid medication? If yes, for how long? \_\_\_\_\_ Yes  No
- 9. Are you taking medications for rheumatoid arthritis? Yes  No
- 10. Has anyone in your family had osteoporosis? Yes  No
- 11. Have you had any fractured bones as an adult? Yes  No
- 12. Have you ever had cancer? Yes  No

13. Have you had a hysterectomy or ovaries removed? When? \_\_\_\_\_ Yes  No   
If yes, please circle what applies: **Uterus ONLY** **Ovaries ONLY** **Uterus AND Ovaries**

14. Are you post-menopausal (periods have stopped)? If yes, when? Yes  No

15. Are you taking or have you ever taken hormone replacement therapy (HRT)? Yes  No   
If yes, what is or was the dose? \_\_\_\_\_ How long? \_\_\_\_\_

16. Are you pregnant? Yes  No

Ordering Provider Name: \_\_\_\_\_ (Please print)

Ordering Provider Signature: \_\_\_\_\_ (Please sign) Date: \_\_\_\_\_

Physician CC: \_\_\_\_\_

Fax # \_\_\_\_\_

Booking Office Use:

Date: _____ Time: _____ Confirmed: _____
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