Testing done HERE at BVMA

BLANCHARD VALLEY MEDICAL ASSOCIATES
200 West Pearl Street
Findlay,Ohio 45840

Appointment Date: ______________________________

Appointment Time: ______________________________ **am pm**

- **Do not take your calcium tablet the morning of your DEXA scan if your appointment is at noon or earlier. If your appointment is in the afternoon you may take your morning calcium, but do not take your calcium at lunch. Bring your calcium and multiple vitamin bottles with you to the test.**

- **Please check in on the West End of BVMA (Closest to the quarry)-DO NOT GO TO THE HOSPITAL**

- **Bring COMPLETED survey with you (all pages, both sides) *ANSWER ALL QUESTIONS to the best of your ability.**

- **Wear comfortable clothing WITHOUT buttons and zippers if possible (Women will be asked to remove bras, sports bras may be left on if they have no metal or plastic)**

- **DO NOT wear strong perfume or cologne**

- **Testing will take approximately 30 minutes**

- **Please check with your insurance to make sure a Bone Density test is a covered benefit. Medicare will cover it every 2 years, but NOT before 2 years.**

- **Call Sherry Nichols (419) 427-1583 with any questions.**

BLANCHARD VALLEY MEDICAL ASSOCIATES

DATE:______________ ____ 1. Name:____

2. Date of Birth:__________ 3. Age: _______ 4. Female Male 5. Height:______ Weight______

6. Ancestry: White Black Asian Hispanic Other__________ 7. Are you Right Handed or Left Handed

8. Which doctor ordered this test?______________________ Send copy of report to:________________

9. Is this your first bone density? ☐ YES ☐ NO If 'NO', where was it done?__________________

10. Are you aware that this procedure uses x-rays? ☐ Yes ☐ No

11. Have you ever been told you have Osteopenia or Osteoporosis (circle one if yes)

12. Do you have a family history of Osteoporosis? ☐ Yes ☐ No
Has your mother, grandmother or sister had a hip or spine fracture? (circle one) ☐ Hip ☐ Spine

13. Have <u>you</u> ever had any fractures of...?

	YES	NO	DATE/or AGE
Vertebrae (spine)	☐	☐	____________
Femur (hip)	☐	☐	____________
Pelvis	☐	☐	____________
Forearm/wrist	☐	☐	____________
Other (specify)	☐	☐	____________

14. Do you now or did you ever smoke? ☐ Yes ☐ No If yes, how many packs per day? ___________
How many years? ______________ If you quit, how many years ago? _______________________

15. Have you ever weighed 127 pounds or less since you were 18? ☐ Yes ☐ No

16. Have you lost height? ☐ Yes ☐ No If yes, how many inches? ________

17. Have you ever been treated with prednisone? ☐ Yes ☐ No If yes, for what condition? ______________
For how long? ______________ What was your average daily dose? __________________

18. Do you exercise regularly? ☐ Yes ☐ No If yes, describe ______________________________

19. Are you having any back pain? Neck______ Upper Back (T Sp)______ Lower Back (LS Sp)__________

20. Have you fallen in the last year? ☐ Yes ☐ No If yes, how did you fall? ____________________

21 Do you wear glasses? ☐ Yes ☐ No

22. Medicines that you currently take or have taken in the past two (2) months.

Please list medication	Dose	How long have been taking

<u>Please fill out the BACK of this survey also.</u>

23. Have you ever taken:

	Taking Now (dose/how long)	In Past (how long)
Calcitonin/Miacalcin	☐ ______	☐ ______
Didronel	☐ ______	☐ ______
Evista	☐ ______	☐ ______
Fosamax/Actonel/Boniva/Forteo/Reclast	☐ ______	☐ ______
Diuretics-specify	☐ ______	☐ ______
Testosterone	☐ ______	☐ ______
Synthroid	☐ ______	☐ ______

24. Have you had any of the following:

	YES	NO	DATE
Curvature of the spine (scoliosis)	☐	☐	______
Rheumatiod Arthritis	☐	☐	______
Lupus	☐	☐	______
Chronic kidney disease	☐	☐	______
Kidney Stones	☐	☐	______
Bowel Surgery or Intestinal Disease	☐	☐	______
Problems digesting/absorbing food	☐	☐	______
Diabetes	☐	☐	______
Thyroid Problems	☐	☐	______
Epilepsy (on anticonvulsant therapy)	☐	☐	______
Alcoholism	☐	☐	______
Chronic Liver Disease	☐	☐	______
Blood Clots	☐	☐	______
If yes, were you on estrogen?	☐	☐	______
Part of stomach/intestines removed	☐	☐	______
Spinal surgery	☐	☐	______
Hip Replacement Surgery	☐	☐	______

25. Do you or did you **avoid** milk? ☐ YES ☐ NO If yes, between what ages?______

26. Number of dairy servings each day _____ (1 dairy serving equals 8oz milk or yogurt, 1 oz cheese)

27. Do you take a calcium supplement? ☐ Yes ☐ No
Which kind?(carbonate, citrate, phosphate) ______ How many milligrams per day? ______

28. Do you take a multivitamin? ☐ Yes ☐ No

29. How much caffeine (soda, coffee, tea) do you drink per day? ______

------------------------**For Women Only**------------------------

30. Between the ages of 20 and 40 years old, how many periods did you have per year?
☐ 12 ☐ 6 – 12 ☐ less than 6

31. Have you missed your periods for more than six (6) months in a row, not including pregnancy/menopause?
☐ Yes ☐ No

32. Have you had a natural menopause? ☐ Yes ☐ No **How old were you?**______

33. If you have had menopause, have you ever taken hormone (estrogen) replacement therapy? ☐ Yes ☐ No
If yes, for how many years? ☐ <1 ☐ 1 – 3 ☐ 3 – 5 ☐ >5 ☐ >10
Are you on estrogen now? ☐ Yes ☐ No
If yes, what kind? ☐ Estrogen pills (premarin, Ogen, Prempo, etc.) Dose______
☐ Estrogen Patch Dose______
If you stopped taken estrogen, why? ______

34. Have you had any of the following surgeries?

Hysterectomy	☐ Yes	☐ No	Date:______	Age:______
Ovaries Removed	☐ Yes	☐ No	Date:______	Age:______
Uterus or Cervix Cancer Surgery	☐ Yes	☐ No	Date:______	Age:______
Breast Cancer Surgery	☐ Yes	☐ No	Date:______	Age:______
Family history of Breast Cancer	☐ Yes	☐ No	Date:______	Age:______