WE CARE FOR ALL WOMEN AT ALL TIMES

WOMEN'S MEDICAL CENTER

PATIENT INSTRUCTIONS FOR A

BONE DENSITY SCAN

Your bone density scan is very comfortable and will take a total of approximately 30 minutes. It does not require any injections or treatments in preparation. The following instructions will help us make this test a positive experience for you and your physician.

1. **DO NOT TAKE ANY CALCIUM SUPPLEMENTS FOR 4 DAYS BEFORE YOUR TEST!!** This includes calcium fortified foods such as Minute Maid orange juice fortified with calcium.

2. Do not have any x-rays with dyes done within 3-5 days of your test.

3. Wear a jogging suit **OR** apparel that **does not have metal or plastic such as zippers, buttons, belts, etc**. Cotton clothing is best.

3. Notify us if you are pregnant or think you might be.

4. Please call at least 24 hours in advance to reschedule.

WOMEN'S MEDICAL CENTER, L.L.P.

OBSTETRICS | GYNECOLOGY | GYNECOLOGIC SURGERY

2000 W. 21st St., Suite A-1, Clovis, NM 88101 | 575-762-8055

Name: _____ **Date:** _____

Sex: ☐ **Female** ☐ **Male** **Date of Birth:** _____

Race: ☐ **Caucasian** ☐ **Hispanic** ☐ **African American** ☐ **Asian**

Referring Physician: _____

(If you wish a copy of your bone density report to go to an additional provider/doctor, please let our receptionist know)

Have you ever had a Bone Density Study before? ☐ **Yes** ☐ **No**

If yes, When? _____ **Where?** _____

LIFESTYLE

Do you drink more than two alcoholic beverages per day?	☐ Yes	☐ No
Do you smoke?	☐ Yes	☐ No

If yes, How much per day? _____

MEDICAL HISTORY

Have you ever had cancer?	☐ Yes	☐ No

If yes, What type? _____

When? _____

Have you ever fractured any bone(s)?	☐ Yes	☐ No

If yes, Which bone? _____

At what age? _____

How? _____

Do you have any metal implants?	☐ Yes	☐ No

If yes, Where? _____

Have either of your parents suffered a broken hip?	☐ Yes	☐ No
Do you have Insulin Dependent Diabetes Mellitus?	☐ Yes	☐ No
Do you have Osteogenesis Imperfecta?	☐ Yes	☐ No
Do you have partial or complete paralysis?	☐ Yes	☐ No
Do you have Hyperthyroidism (overactive thyroid)?	☐ Yes	☐ No
Do you have Hyperparathyroidism (overactive parathyroid glands)?	☐ Yes	☐ No
Do you have kidney failure (on dialysis or may need it in the future)?	☐ Yes	☐ No

Do you have **RHEUMATOID** arthritis (**NOT** osteoarthritis or gout)? ☐ Yes ☐ No

Has part of your stomach been removed (gastrectomy or weight loss surgery)? ☐ Yes ☐ No

Do you have an intestinal disease (Crohn's Disease, Ulcerative Colitis, Sprue)? ☐ Yes ☐ No

Do you have a history of DVT (Deep Vein Thrombosis)? ☐ Yes ☐ No

Do you have any form of liver disease? ☐ Yes ☐ No

Do you have Lupus? ☐ Yes ☐ No

Have you had any testing/procedure in the last 72 hours using contrast dye? ☐ Yes ☐ No
(i.e. for IVP, barium enema, upper GI, x-rays)

IF YES, PLEASE LET OUR RECEPTIONIST KNOW

GYNECOLOGICAL HISTORY

Are you pregnant or could you be pregnant? ☐ Yes ☐ No

Please indicate the **FIRST DAY** of your last menstrual period: _____

Have you had your uterus removed? ☐ Yes ☐ No

If yes, When? _____

Was there any cancer? _____

Have you had your ovaries removed? ☐ Yes ☐ No

If yes, When? _____

Was there any cancer? _____

Have you stopped your periods permanently? ☐ Yes ☐ No

If yes, At what age? _____

Are you taking hormone replacement therapy? ☐ Yes ☐ No

Please fill out medications on next sheet

MEDICATIONS

The following medicines and supplements may be used to treat osteoporosis.

Please place a check beside each one you are taking:

- ☐ Actonel dosage _____ how long _____
- ☐ Alendronate (Fosamax) dosage _____ how long _____
- ☐ Calcitonin (Fortical, Miacalcin) dosage _____ how long _____
- ☐ Boniva dosage _____ how long _____
- ☐ Calcium Supplement
  - ☐ dose unknown
  - ☐ 500-900mg/day
  - ☐ 1000-1499mg/day
  - ☐ 1500mg or more/day
  - ☐ Vitamin D
- ☐ Estrogen (Premarin, Ogen, Estraderm, or Vivelle Patch)
- ☐ Estrogen & progestin (Prempro, Premphase, Premarin & Provera
- ☐ Estrogen & testosterone (Estratest)
- ☐ Raloxifene (Evista)
- ☐ Natural hormones (DHEA, Tri-estrogen, Progest, Progesterone)

If you are taking any of the above are you faithful about it? ☐ Yes ☐ No

Do you take any anti-convulsants (for seizures/epilepsy)? ☐ Yes ☐ No

Are you now on a form of cortisone (such as prednisone)? ☐ Yes ☐ No

If yes, Name of medication: _____

Dose: _____

What is it for? _____

How long have you been on it? _____

Please list any other medications you take regularly:

MEDICATION	REASON FOR TAKING