ARTHRITIS CONSULTANTS OF TIDEWATER

RHEUMATOLOGY · OSTEOPOROSIS & INFUSION CENTERS
PHONE (757) 491-7359 · FAX (757) 491-9359

GARY R. SIEGEL, M.D., F.A.C.R.
MICHAEL R. CANNON, M.D., F.A.C.R.
SALLY CLARK, FNP-C
EMILY HERNANDEZ MACKIE, PA-C
TATIANA KECK, M.D., F.A.C.R.
JANICE SHERWOOD, M.D., F.A.C.R.
ROOPA ACHURI, PA-C

Name: _____ Referring Doctor: _____

Date of Birth: _____ Primary Doctor of Care: _____

Sex: _____ Race: _____ SSN: XXX-XX-_____

Have you ever had a bone density study before? ☐ Yes ☐ No

Was it within 2 years? ☐ Yes ☐ No

What was your maximum height? _____ ft. _____ in.

What is your weight? _____ lbs.

Are you pregnant or do you suspect that you are pregnant? ☐ Yes ☐ No

Have you been diagnosed with osteoporosis? ☐ Yes ☐ No

Has anyone in your family ever fractured a hip? ☐ Yes ☐ No

(If yes) Who? _____

Have you had a fracture? ☐ Yes ☐ No

(If yes) Date of fracture?_____

(If yes) What was fractured? _____

Have you had surgery on your back? ☐ Yes ☐ No

Have you had surgery on your hip? ☐ Yes ☐ No

Have you had surgery on your abdomen? ☐ Yes ☐ No

Do you have metal implants? ☐ Yes ☐ No

(If yes) Where?_____

Have you ever been a smoker? ☐ Yes ☐ No

(If yes) How many packs per day? _____

(If yes) Have you quit smoking? ☐ Yes ☐ No

How many caffeinated drinks do you drink per day?

_____

ARTHRITIS CONSULTANTS OF TIDEWATER

RHEUMATOLOGY · OSTEOPOROSIS & INFUSION CENTERS
PHONE (757) 491-7359 · FAX (757) 491-9359

GARY R. SIEGEL, M.D., F.A.C.R.
MICHAEL R. CANNON, M.D., F.A.C.R.
SALLY CLARK, FNP-C
EMILY HERNANDEZ MACKIE, PA-C
TATIANA KECK, M.D., F.A.C.R.
JANICE SHERWOOD, M.D., F.A.C.R.
ROOPA ACHURI, PA-C

Have you reached menopause? ☐ Yes ☐ No
(If yes) At what age? _____

Have you had a hysterectomy? ☐ Yes ☐ No
(If yes) Date? _____

Have both of your ovaries been removed? ☐ Yes ☐ No
(If yes) Date? _____

Have you ever taken birth control pills? ☐ Yes ☐ No
(If yes) How long? _____

Do you exercise regularly? ☐ Yes ☐ No
How many days per week? _____
How long per day? _____

Have you ever used steroid drugs? ☐ Yes ☐ No
(If yes) How long? _____

Have you ever used any inhaled steroids? ☐ Yes ☐ No
(If yes) What kind of inhaler? _____
(If yes) How long? _____

Have you ever taken thyroid medications? ☐ Yes ☐ No
(If yes) Which medication? _____
(If yes) How long? _____

Are you allergic to any medications? ☐ Yes ☐ No
(If yes) What?_____

Have you ever been diagnosed with hyperparathyroidism? ☐ Yes ☐ No

Do you have an elevated calcium level? ☐ Yes ☐ No

Please list ALL current medication: _____
_____
_____