Appointment Date and Time: ____

PATIENT BONE DENSITY INSTRUCTIONS

1. Please arrive 15 minutes early to fill out paperwork, or bring it with you
2. If you wear an elastic waistline you will not have to change into a gown. Try to eliminate any metal around your waistline such as snaps, buttons, or zippers.
3. No barium or dye studies one week prior to the Bone Density Test.
4. Do not take any Calcium supplements the evening prior to, or the day of your test.
5. Bring a list of all your medications including any Calcium and Vitamin D supplements.
6. Bring your ID and all insurance cards.

BEALS INSTITUTE
OSTEOPOROSIS CLINIC
4333 W. ST. JOE HWY
LANSING, MI 48917

Welcome to our Office: Date: ____________________

Patient's name ____

Address ______________________ E-mail ______________________

City ____________________ State ______________ Zip ______________

Phone (____)__________ Date of Birth ____________ SSN# ______________

Employer ______________________ Occupation ______________________

Business Address ______________________ Bus. Phone (____)__________

Name of Parents (if child) ______________________________________

Full Name of Spouse ______________________ Date of Birth ____________

Spouse or Parent Employed by ____________________ Occupation ____________

Business Address ______________________ Bus. Phone (____)__________

Referred by ____

Primary Care Physician ______________________________________

Osteoporosis Questionnaire

Name ____________________________________ **DOB**________________ **Date** ________________

Sex _____ Race _____________ Family Background / Ethnicity (ie: German) ___________________

Peak Adult Height __________ ***Office use only:*** ***Current Height*** _______***Weight*** ___________

Osteoporosis History:

Have you ever had a bone density test before? Yes _____ No _____

If yes, when and where did you have it? ______________________________________

Did your previous bone density scan diagnose you with osteopenia or osteoporosis? Yes _____ No _____

Are you currently taking any osteoporosis medications? Yes ___ No____ If yes, list name. ________________

Have you discontinued any osteoporosis medications? Yes ____ No ____ If yes, list name of medication and why you discontinued it. ____

Do you have a family history of osteoporosis? Yes ___No ___ Relationship: ___________________________

Has either of your parents ever fractured a hip? Yes ___ No ___ If yes, how did it occur? ________________

Bone Fracture History: Have you ever fractured or broken a bone after the age of 40 yrs? Yes ____ No____

Bone Broken	How did it Happen?

Menstrual History:

Are you postmenopausal (stopped having periods for more than 1 year)? Yes___ No___ If yes, what age? _____

Are you currently having symptoms of menopause? Yes ___ No ___ If yes, what was the age of onset? _____

Have you had a hysterectomy? Yes ___No___ If yes, what age? _____

Have you had **both** ovaries removed? Yes ___ No___ If yes, what age? _____

Medication History: Are you or have you ever taken any of the following medications?

Medication	Yes	No	How Many Years?	If in past, when stopped?
Antiseizure drugs (Dilantin, Phenobarbital)				
Medication to prevent return of cancer				
Hormone replacement therapy				
Hormone suppressing agents (Lupron, Depo Provera)				
Steroids (prednisone, orisone, deltasone)				

Technician comments:

____

____

____

Name ______________________ **D.O.B.** __________ **Date** ______________

Medical History:

Have you ever had or currently having any of the following health problems? Please check or answer below.

Back pain (specify) low, mid, upper

Back surgeries (type) ________

Autoimmune disorder ________

Thyroid disease _____

Hyperparathyroidism _____

Frequent falls ______

Eating disorder _____

Cancer (type) _________

Chemo/Radiation _____

Kidney disease _____

Vitamin D deficiency _____

Stomach disorder (specify) _______

Stomach surgery (type) __________

Intestinal disorder (specify) _______

Intestinal surgery (type) __________

Bariatric surgery _________

Exercise History:

How often do you exercise? ______________________

What type of exercise do you usually do? ____

Smoking:

Do you smoke? Yes: _____ No: _____ How many years? ______ If you quit, when did you quit? ____________

Alcohol:

Do you drink three or more servings of alcohol on a daily basis? Yes: ______ No: _______

Calcium and Vitamin D Assessment:

How many servings of calcium rich foods do you average per day? ________________

Do you take a calcium supplement? Yes: ________ No: __________

If yes, how many milligrams per day? ____________

Do you take vitamin D? Yes: ________ No: __________

If yes, how many IU of vitamin D per day? __________

Medication:

WELCOME TO THE BEALS INSTITUTE

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the Beals Institute to release any medical or incidental information that may be necessary for either medical care or in processing applicants for financial benefits.

ASSIGNMENT OF INSURANCE BENEFITS

- I hereby direct payment of surgical/medical benefits to the Beals Institute for services rendered by him/her in person or under his/her supervision
- I understand that I am financially responsible for any balance not covered by my insurance.
- I certify that the information given by me on the ages below is current and correct.
- I request that payment of authorized benefits made be made on my behalf
- I have reviewed and agree with the Beals Institute privacy practices.

BONE DENSITY FOLLOW UP VISIT

Bone density follow up counseling appointments are billed as a separate office call. The fee for these appointments is ***not*** included in the bone density scan charge.

RECORDS RELEASE

There is a records fee for copying and mailing reports to patients. You may get a copy for fee at your Bone density follow up appointment. Your primary care physician or ordering doctor will be sent a copy of the report.

Patient Name (print) ________________________________ DOB ______________

Patient signature ________________________________ Date ______________

Parent/Guardian ________________________________ Date ______________