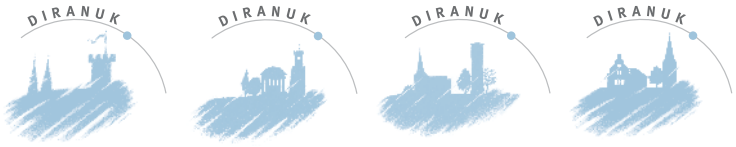
Patientenetikett



MVZ DIRANUK GmbH – Bielefeld | Bad Salzuflen | Gütersloh | Bünde

CASE HISTORY QUESTIONNAIRE BONE DENSITY SCAN

Dear patient, please answer the following questions.

Surname First name Age

_____

Body height _____ cm Body weight _____ kg

Have you ever had a bone density scan before? ☐ yes ☐ no
If yes, please state when and where. _____
Have you previously been diagnosed with osteoporosis? ☐ yes ☐ no
If yes, please state when and where. _____
Are we permitted to request the findings for comparison? ☐ yes ☐ no
Do you take medication for osteoporosis? ☐ yes ☐ no
If yes, which medication are you taking? _____

Have you had one or more vertebrae fractures? ☐ one fracture ☐ several fractures ☐ yes ☐ no
Have you had one or more fractures after you turned 50? ☐ yes ☐ no
If yes, which fractures? _____
Do you have an artificial hip joint? ☐ yes ☐ no
If yes, on which side? ☐ left ☐ right ☐ both sides
Have you been or are you undergoing cortisone therapy (steroids)? ☐ yes ☐ no
If yes, what is the dosage? _____
Do you have an overactive parathyroid (= hyperparathyroidism)? ☐ yes ☐ no

Have you been or are you being treated with aromatase inhibitors? ☐ yes ☐ no
Have you been or are you undergoing antiandrogen therapy? ☐ yes ☐ no
Are you deficient in estrogen? ☐ yes ☐ no
Do you suffer from a lack of growth hormones due to pituitary disease? ☐ yes ☐ no
Do you suffer from a rheumatic illness? ☐ yes ☐ no

Did one of your parents sustain a femural neck fracture? ☐ yes ☐ no
Do any of your family members suffer from osteoporosis? ☐ yes ☐ no
Are you underweight? ☐ yes ☐ no
Is it difficult for you to move about and/or do you lack physical exercise? ☐ yes ☐ no
Do you smoke? ☐ yes ☐ no
Do you take sleeping pills ? ☐ yes ☐ no
Do you take medication that can cause dizziness? ☐ yes ☐ no
Do you take antidepressants? ☐ yes ☐ no
Do you take neuroleptics = antipsychotics? ☐ yes ☐ no
Do you suffer from diabetes? ☐ yes ☐ no
If yes, which medication are you taking? _____
Have you had an operation on your stomach? ☐ yes ☐ no
Do you suffer from an overactive thyroid? ☐ yes ☐ no
Do you suffer from epilepsy? ☐ yes ☐ no

You are entitled to a copy of this medical history questionnaire. (Under Section 630 e, sub-section 2, sentence 2, BGB)
☐ I do not require a copy of this medical history questionnaire. ☐ I would like a copy of this medical history questionnaire.

I agree to the planned medical examination.

_____ _____
Place, Date Signature Patient

0403 – 10.2023