Bone Density History

PATIENT INFORMATION

Fall Precaution ☐ YES ☐ NO

Last Name	**First Name/Middle Initial**	**Gender**	**Race**
Date of Birth (MM/DD/YYYY) / /	**Age**	**Height**	**Weight**

MEDICATIONS

List any current medications:

________________________________ ________________________________ ________________________________

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Do you take osteoporosis medication? ☐ YES ☐ NO If yes, what kind and how long? ________________________

Do you take Glucocorticoids? ☐ YES ☐ NO

PERSONAL HISTORY

Are you still having periods? ☐ YES ☐ NO **Has either parent had a hip fracture?** ☐ YES ☐ NO

Drink more than 3 alcoholic drinks a day? ☐ YES ☐ NO **Have you ever had a fracture as an adult?** ☐ YES ☐ NO

Are you a current smoker? ☐ YES ☐ NO **Do you have rheumatoid arthritis?** ☐ YES ☐ NO

PRIOR IMAGING & SURGERIES

Any surgery to your hip or lumbar spine? ☐ YES ☐ NO

If yes, please explain: ____

In the last three days have you had a Barium x-ray, CT, or Nuclear Medicine Test? ☐ YES ☐ NO

If yes, please explain: ____

TECHNOLOGIST COMMENTS

____ ____

TECHNOLOGIST SIGNATURE **DATE & TIME**