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Bone Densitometry Exam

Date: ___/___/____

Patient's Name ____
(Last) **(First)** **(M.I)**

Date of Birth ___/__/___ **Age**_______ **Sex**__________

Have you ever had a Bone Densitometry exam before? Yes____ No____

If so, when and where____

Indications for the test____

____

Please list all the medications you are currently taking:___________________________

____

Do you have any allergies? Please list:____

____

Are you currently smoking?__________________ If not, do you have a history of smoking?__________

(Female Patients ONLY)

Last Menstrual Period___/___/____

Family History of: Osteoporosis: _________ Cancer (type): _____________________

Personal History of: Osteoporosis: _______ Surgery: Hip or Spine Cancer (type): _________________

Was Osteoporosis Previously Diagnosed? Yes_____ When___/___/_____
Medications (list type):

Steroids:______________________ Calcium Intake:________________ Vitamins:____________________
Antihypertensives:____________________________ Exercise:_________________________________

(Male Patients ONLY)

Family History of: Osteoporosis: _________ Cancer (type): _____________________

Personal History of: Osteoporosis: _______ Surgery: Hip or Spine Cancer (type) : _________________

Was Osteoporosis Previously Diagnosed? Yes_____ When___/___/____
Medications (list type):
Steroids:______________________ Calcium Intake:________________ Vitamins:____________________
Antihypertensives:____________________________ Exercise:_________________________________

Comments: ____

____

____

Technologist: ________