



# BONE DENSITY HISTORY FORM

## Patient Information

Patient Name: \_\_\_\_\_ Patient #: \_\_\_\_\_ Date: \_\_\_\_\_

Weight: \_\_\_\_\_ Current Height: \_\_\_\_\_ Tallest Height: \_\_\_\_\_ Procedure: Bone Density

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Referring Physician: \_\_\_\_\_ Sex:  M  F

Race: \_\_\_\_\_

Why are we performing this procedure? \_\_\_\_\_

Have you had a previous bone density procedure?  Yes  No If yes, when? \_\_\_\_\_

Name of facility: \_\_\_\_\_

## Have you been treated with any of the following medications?

MEDICATION	EVER?	CURRENTLY?	FOR HOW LONG?
Hormone Replacement (Estrogen)			
Tamoxifen, Zoledronic acid (Zometa)			
Testosterone			
Osteoporosis medications (Fosomax, Actonel etc.)			
Corticosteroids (Cortisone or Prednisone)			
Seizure medication?			
Thyroid medications or Sythroid			

Other medications you are presently taking: \_\_\_\_\_

List any drug, latex or food allergies: \_\_\_\_\_

List previous surgeries: \_\_\_\_\_

### **Please answer these questions:**

Enter your zip code: \_\_\_\_\_

Right  Left Are you right or left handed?

Yes  No Have you been through menopause? If yes, what age: \_\_\_\_\_

Yes  No Have you had a nuclear medicine procedure in the past 10 days?

Yes  No Have you had a barium x-ray procedure in the past three to seven days?

Yes  No Have you had any IV x-ray contrast in the past seven days?

Yes  No Do you take calcium supplements daily? If yes, what kind and dose? \_\_\_\_\_

Yes  No Have you ever been diagnosed with cancer? If yes, what type? \_\_\_\_\_

Yes  No Have you had a broken bone in your adult life? If yes, which bone? \_\_\_\_\_

Yes  No Have you ever had fractures or surgery on your hips, back or wrists? If yes, when and what did you fracture? \_\_\_\_\_

- Yes  No Do you smoke? If yes, # of years: \_\_\_\_\_ Packs per day: \_\_\_\_\_
- Yes  No Is your diet low in dairy products and other sources of calcium?
- Yes  No Do you drink alcohol? If yes, how many drinks per day? \_\_\_\_\_
- Yes  No Are you pregnant now?
- Yes  No Have you ever been pregnant?
- Yes  No Do you have irregular periods?
- Yes  No Have you had a hysterectomy? Date: \_\_\_\_\_ If yes, were both ovaries removed? \_\_\_\_\_
- Yes  No Do you exercise? If yes, how often? \_\_\_\_\_
- Yes  No Have you ever had an eating disorder? If yes, explain: \_\_\_\_\_

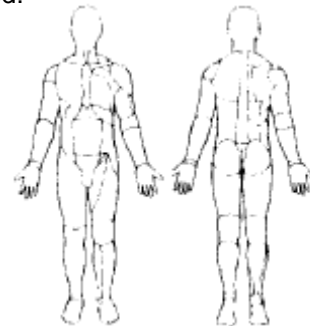
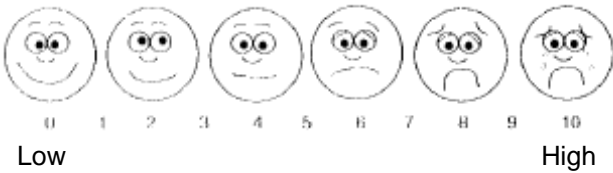
**DO YOU HAVE OR EVER HAD ANY OF THE FOLLOWING?**

- |                              |                             |                                 |                              |                             |                                |
|------------------------------|-----------------------------|---------------------------------|------------------------------|-----------------------------|--------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Parathyroid disease             | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Chemotherapy                   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Excessive tooth decay/ breakage | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Family history of osteoporosis |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Rheumatoid arthritis            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Thyroid disease or surgery     |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | On-going back pain              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Diabetes/self or family        |

Do you have pain?  Yes  No

Draw on the figures where the pain/symptoms are located:

How long have you had pain? \_\_\_\_\_  
Pain Rating/Intensity:



**Acknowledgement:** I have answered these questions to the best of my knowledge and understand the information presented to me. I have also informed the technologist that I am not pregnant at this time. I give consent to the performance of a Bone Density Procedure at Premier Diagnostic Center.

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Technologist/Witness Signature

\_\_\_\_\_  
Date

**Clinical Use Only**

Patient Education given:  Verbal  Brochure  Video Identify: \_\_\_\_\_