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

Drink more than 3 alcoholic drinks a day? ☐ YES ☐ NO

Are you a current smoker? ☐ YES ☐ NO

Has either parent had a hip fracture? ☐ YES ☐ NO

Have you ever had a fracture as an adult? ☐ 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**