PREMIER MEDICAL IMAGING

Bone Density Patient History Form

**** This exam uses equipment that produces radiation ****

Name: ____ MR #: ________________________________

Date of Birth: ________________________ Height: ___________________ Weight: ____________________

Referring Physician: _______________________________ Sex: Male Or Female

Race: African American Asian Caucasian Hispanic Native American Other

	YES	NO
1. Have you ever had a bone density test? If so, where? ____	YES	NO
2. Have you ever been treated for osteoporosis/weak bones?	YES	NO
3. Have you fractured any bones during your adult life? If so, which ones? ___________________________________	YES	NO
4. Have you had any height loss?	YES	NO
5. Do you have a family history of osteoporosis?	YES	NO
6. Do you smoke cigarettes, or been a regular smoker in the past?	YES	NO
7. Do you drink more than 2 alcoholic beverages in a day?	YES	NO
8. Do you take a calcium supplement?	YES	NO
9. Have you taken steroid treatments for an extended period of time?	YES	NO
10. Have you taken, or are currently taking thyroid medication?	YES	NO
11. Have you been diagnosed with arthritis? If so, what kind? ____________________________________	YES	NO
12. Have you had a nuclear medicine scan within the last 5 days?	YES	NO
13. Have you had any barium products within the last 7 days?	YES	NO
14. Have you had an injection of CT contrast (Iodine) in the last 30 days?	YES	NO

Remaining Questions are for Female Patients Only

	YES	NO
15. Is there any chance of Pregnancy?	YES	NO
16. Are you past Menopause (change of life)? If so, what age? ____________________________________	YES	NO
17. Have you had a hysterectomy? If so, Partial or Total? _________________________________	YES	NO
18. Are you on hormone replacement therapy (HRT)? If so, how long? ____________________________________	YES	NO