DIAGNOSTIC IMAGING CENTERS, P.A.

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BONE DENSITY SURVEY

Please answer the following questions, checking all that apply to you. If you are unsure of how to answer, leave the question unanswered, and we will assist you. All answers will be kept in strict confidence and treated as medical record information.

Name:_____ Date:_____ Referred by:_____

Date of birth:_____ Height:_____ Weight:_____ Sex: ❑ Male ❑ Female

Race: ❑ African American ❑ Asian ❑ Caucasian ❑ Hispanic ❑ Other_____

Have you fractured any bones during your **adult** life? ❑ Yes ❑ No

Is there any current fracture or history of fracture in a first-degree relative? ❑ Yes ❑ No ❑ Child ❑ Parent

Have you been diagnosed with any vertebral compression fractures? ❑ Yes ❑ No

Have you fractured or had surgery on your femur (including hip)? ❑ Yes ❑ No (if yes) ❑Right ❑Left

Have you fractured or had surgery on your forearm/wrist? ❑ Yes ❑ No (if yes) ❑Right ❑Left

Have you had any surgery on your low back? ❑ Yes ❑ No

Are you a current smoker? ❑ Yes ❑ No

Have you had a Bone Density Scan (DEXA)? ❑ Yes ❑ No (if yes) Date:_____

Where:_____

Have you taken/are taking any of the following medications? If yes, please indicate name of medication.

❑Actonel (Risedronate) ❑Anticonvulsants (for seizure, epilepsy) ❑Boniva ❑Calcium ❑Chemotherapy ❑Evista (Raloxifene) ❑Forteo

❑Fosamax (Alendronate) ❑Heparin ❑Hormones ❑Levothroid ❑Levothyroxine ❑Levoxyl ❑Lithium

❑Loop diuretics (Lasix, Burnex, Edecrin) ❑Methotrexate ❑Miacalcin/calcitonin ❑Reclast ❑Steroids ❑Synthroid ❑Unithroid

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Please check **all** that apply to you:

❑Amenorrhea ❑Breast CA ❑Corticosteroid (adrenal) disease ❑Diabetes ❑Eating disorders (anorexia nervosa, bulimia, etc.)

❑Family history of Osteoporosis ❑Hyperparathyroidism ❑Hyperthyroidism ❑Loss of height

❑Malabsorption (due to stomach or intestinal surgery, Crohn's, etc.) ❑Osteopenia ❑Osteoporosis

❑Prostate CA ❑Renal disease ❑Scoliosis

Have you had any of the following exams in the last 10 days? ❑ Nuclear Medicine ❑ CT

When and what type?_____

❑Hysterectomy ❑Ovaries Removed ❑Postmenopausal ❑Date of last Menstrual Period _____

Patient signature:_____