BONE DENSITY PATIENT HISTORY FORM

Patient Name: _____ MR#: _____ Date: _____

DOB: _____ Age: _____ Ordering Physician: _____

ALL FEMALES: Date of last menstrual period: _____ Are you or could you be pregnant? ☐ YES ☐ NO

Are you breast feeding? ☐ YES ☐ NO Are you postmenopausal? ☐ YES ☐ NO

Have you had a bone density exam before? ☐ YES ☐ NO

If yes, where did you have the scan done and the approximate date it was done:_____

_____

If you know what part of the body was scanned please circle: **LUMBAR SPINE HIP OTHER**

What were the results of the last scan done? _____

_____

Are you taking any medication for osteoporosis? ☐ YES ☐ NO

If yes, what medication for osteoporosis are you currently taking? _____

Are you currently on any thyroid medication? ☐ YES ☐ NO

If yes, what thyroid medication are you currently taking? _____

I attest the above information is corect to the best of my knowledge. I have read and understand the content of this form. I have had the opportunity to ask questions regarding the procedure I am about to undergo.

Patient/Guardian Signature: _____ Today's Date: _____

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