



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:

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 Has either parent had a hip fracture? YES NO

Drink more than 3 alcoholic drinks a day? YES NO Have you ever had a fracture as an adult? YES NO

Are you a current smoker? 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