HUDSON VALLEY RADIOLOGY ASSOCIATES

☐ MRI

BONE DENSITOMETRY

PATIENT HISTORY

Name: _____ Today's Date: _____

Sex: M F Social Security #: ____/____/____ Height : _____ Weight : _____

Date of Birth: _____ Age: _____ Referring Doctor(s): _____

Previous Bone Density: Yes No Date: _____

INTAKE MEASURES

Yes	No	
		a) Is there family history of Osteoporosis?
		b) Are you pre-menopausal with heavy menstrual bleeding?
		c) Are you menopausal with symptoms such as flushing, sleeplessness, headache, lack of concentration?
		d) Are you both postmenopausal without symptoms?
		e) Have BOTH of your ovaries been removed?
		f) Have you ever been diagnosed with Calcium or Vitamin D deficiency?
		g) Have you a previous fracture of the hip and spine, or multiple fractures without significant trauma?
		h) Are you Caucasian or Asian American?
		I) Do you have a thin body build?
		j) Do you have a history of Thyroid Disease or long term Synthroid use (longer than 3 months?)
		k) Do you have Hyperparathyroidism?
		l) Do you take medication for chronic seizures?
		m) Any history of chronic steroid use?
		n) Any history of chronic renal failure?
		o) Have you smoked more than 1 pack/day for more than 10 years?
		p) Do you have any history of Anorexia or Bulimia?
		q) Do you have Cushing's disease or Syndrome?

THERAPEUTIC MEASURES

Yes	No	
		a) Do you take Calcium or Vitamin D supplements?
		b) Do you exercise, walk or lift weights at least 3 times per week.
		c) Are for taking Fosomax? How long? _____
		d) Are you taking Actonel? How long? _____
		e) Are you taking Evista? How long? _____
		f) Are you taking Calcitonim How long? _____

_____ Patient Signature

_____ Reviewing Technologist