MEDICAL IMAGING OF MANHATTAN, LLC

Account#_____ Technologist:_____ Date:_____

Bone Densitometry Worksheet

Name: _____ Age: _____ D.O.B. _____

Are you pregnant? [ ] YES [ ] NO

Have you ever had a Bone Densitometry performed before? [ ] YES [ ] NO

If Yes, when and where?

_____

_____

Have you experienced menopause? [ ] YES [ ] NO

If YES, at what age: _____

In the past 7 days have you had any of the following?

[ ] Barium Contrast Study [ ] Cat Scan (CT Scan) [ ] Nuclear Medicine Study

Place an "X" next to all that apply to you:

	Fractures
	Left hip prosthesis
	Right hip prosthesis
	Spinal implants
	Spinal surgery
	Other_____

	Indications
	Advanced age (70 or older)
	Alcohol (3 or more units/day)
	Amenorrhea
	Bilateral oophorectomies
	Caucasian
	Corticosteroid
	Family hist. (parent hip fracture)
	Family hist. of osteoporosis
	Glucocorticoids (chronic)
	Height loss
	History of fracture (adult)
	Hyperparathyroid
	Hyperthyroid
	Low body weight
	Low calcium intake
	Menopause
	Osteopenia
	Osteoporosis
	Past history of smoking
	Poor health (frailty)
	Recurrent falls
	Renal failure
	Rheumatoid arthritis
	Scoliosis
	Secondary osteoporosis
	Synthroid
	Tobacco user (current)

	Treatments
	Actonel
	Anti-seizure meds (Dilantin)
	Arimidex
	Birth control
	Boniva
	Calcitonin (Miacilin)
	Calcium
	ERT
	Evista
	Fluoride
	Forteo
	Fosamax
	HRT (combo)
	Reclast
	Steroids
	Tamoxifen
	Vitamin D
	Other _____