

# RADIOLOGY ASSOCIATES

## Osteoporosis Evaluation for Bone Mineral Density Exams

Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_

Age: \_\_\_\_\_ yrs      Weight: \_\_\_\_\_ lbs      Height: \_\_\_\_\_      Sex: Male Female      Ethnicity: \_\_\_\_\_

\* **Have you had a previous Bone Mineral Density study (BMD/BMM)?**       YES       NO  
 When? \_\_\_\_\_ Where? \_\_\_\_\_

**Are you taking medication to rebuild bone mass?**       YES       NO

**Which medication are you taking?**

- Alendronate (Fosamax)       Actonel  
 Calcitonin (Miacalcin)       Other: \_\_\_\_\_

**What is your daily dosage?** \_\_\_\_\_ **For how long?** \_\_\_\_\_

\* **Are you currently on Steroid Therapy?**       YES       NO

**Which medication are you taking?**

- Cortisone       Prednisone       Other: \_\_\_\_\_

**What is your daily dosage?** \_\_\_\_\_ **For how long?** \_\_\_\_\_

\* **Do you have hyperparathyroidism?**       YES       NO

**Are you taking medication for this condition?**       YES       NO

**Which medication are you taking?** \_\_\_\_\_

**What is your daily dosage?** \_\_\_\_\_ **For how long?** \_\_\_\_\_

**Have you ever had Hip surgery?**       L     R       Both       NO

**Have you ever had Spinal surgery?**       YES       NO

**Have you ever had a Vertebral Fracture?**       YES       NO

**Are you now or have you ever been a smoker?**       YES       NO

**Are you taking medication for a chronic kidney illness?**       YES       NO

**Have you had a barium x-ray procedure in the past three days?**       YES       NO

**Have you had a Nuclear Medicine procedure in the past ten days?**       YES       NO

**Have you had an intravenous x-ray contrast (dye) in the past seven days?**       YES       NO

**Do you have a family history of osteoporosis?**       YES       NO

**Have you noticed any loss of height?**       YES       NO

**Please check any of the following conditions that you have now or have had in the past.**

- Cancer of the breast       Cancer of the uterus       Excessive tooth decay or breakage

**WOMEN ONLY**

**Are you pregnant or is there any chance of you being pregnant?**       YES       NO

**Do you have irregular periods?**       YES       NO

\* **Have you had a hysterectomy?**       YES       NO

At what age? \_\_\_\_\_ **Both ovaries removed?**       YES       NO

**Have you been through menopause?**       YES       NO

\* **Natural?** \_\_\_\_\_

**Hysterectomy induced?** \_\_\_\_\_

**Are you now or have you ever taken estrogen?**       YES       NO

When? \_\_\_\_\_ For how long? \_\_\_\_\_

HAVE ANSWERED THESE QUESTIONS TO THE BEST OF MY KNOWLEDGE AND UNDERSTAND THE INFORMATION PRESENTED TO ME. I HAVE ALSO INFORMED THE TECHNOLOGIST THAT I AM NOT PREGNANT AT THIS TIME.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Technologist Signature

\_\_\_\_\_  
Date

