



Exam Date: _____

X-Ray #: _____

Name: _____ Referring Physician: _____

SSN: _____ Date of Birth: _____

Ethnicity (Circle One): Caucasian African American Asian Hispanic Other _____

What was the date of your last menstrual period? _____

If you have passed menopause, estimate the year of your last menstrual cycle: _____

Have you had a bone density examination before? Y or N

If so, at which medical facility? _____

If so, when was your last bone density exam? _____

Are you right or left handed? RIGHT LEFT

Have you had a hip replacement? Y or N If so, which hip, Right, Left, Both? _____

Have you had any previous fractures as an adult? Y or N

Have you had any surgery on your lower back? Y or N

If so, which procedure(s)? Please list _____

Have you had any examination within the past 7 days where you were injected with or ingested a contrast material, i.e. Barium? Y or N

Weight: _____ Height: _____ Have you had any noticeable decrease in your height? Y or N

Do you take any of the following medications: (Please check all that apply)

- Actonel (i.e. risedronate)
- Boniva (i.e. ibandronate)
- Evista (i.e. raloxifene)
- Forteo (i.e. parathyroid hormone)
- Fosamax (i.e. alendronate)
- HRT (i.e. estrogen/hormone therapy)
- Miacalcin (i.e. calcitonin)
- Protelos (i.e. strontium ranelate)
- Reclast (i.e. zoledronate)
- Prolia (i.e. denosumab)
- Vitamin D
- Calcium
- Other: _____

Do you have any of the following medical conditions: (Please check all that apply)

- Anorexia or Bulimia
- Any Seizure Disorders
- Asthma or Emphysema
- Cancer
- End stage renal disease
- Inflammatory bowel diseases
- Hyperparathyroidism
- Hysterectomy
- Other: _____