CHOICE
Diagnostic Imaging

BONE DENSITY

PLEASE PRINT. THANK YOU!

Patient Name: _____ Date: _____

DOB: _____ Referring Physician: _____

Height: _____ Weight: _____ Ethnic Origin: _____

PLEASE CIRCLE EACH ANSWER...

Have you had a prior bone density? YES NO

If so, when and where was your prior done? _____

Are you taking any medication for bone density? YES NO

If so, what type? _____ Dosage: _____

Are you pregnant? YES NO

Have you had any recent radiation treatments? YES NO

Have you had any recent nuclear medicine studies? YES NO

Have you ever had any surgery on your lower back? YES NO

If so, what type? _____ Date: _____

Have you ever fractured or had any surgery on your hips? YES NO

COMPARISON TO PRIOR:

Lumbar: _____ % Hip (neck): _____ %

_____ _____

Patient Signature *(Guardian/Parent If A Minor)* Date