New York Private Medical Imaging LLP

BONE DENSITOMETRY SCREENING SHEET

COMPLETED BY PATIENT

PATIENT NAME: DATE:

DATE OF APPOINTMENT: / / DATE OF BIRTH: / / AGE:

REFERRING PHYSICIAN: PHONE #:

Is this your first Bone Density? ☐YES ☐NO

If NO, where was your last test completed:

*Ethnic background

☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ Other

**Asian and Caucasian women have the highest risk for developing osteoporosis. African-American and Hispanic women have a lower but still significant risk.*

Date of last menstrual period: / / Could you possibly be pregnant? ☐YES ☐NO

Menopause Age: Weight: Height:

Are you taking any hormone replacement? ☐YES ☐NO Specify:

List any medication you are currently taking:

Do you have any of the following?

Asthma	☐YES	☐NO	Anorexia	☐YES	☐NO
Kidney Disorder	☐YES	☐NO	Diabetes	☐YES	☐NO
Thyroid Disorder	☐YES	☐NO	Cancer	☐YES	☐NO

Do you have a family history of Osteoporosis? ☐YES ☐NO

Have you ever had any fractures? ☐YES ☐NO

If YES, of what body part and when?:

Were you ever a smoker? ☐YES ☐NO

If you quit, put approximate date:

Do you have any known Scoliosis? ☐YES ☐NO

SCREENED BY: SCREENED WITH:

Technologist comments:

Technologists initials:

I verify that the answers I have provided to questions on this form are correct and understand that withholding information or inaccurate information may adversely affect the interpretation of this exam.

Patients signature: Date: / /