Thompsonhealth

Patient Name: _____
DOB: _____
Medical Record No. _____

DIAGNOSTIC IMAGING: PATIENT HISTORY PRE BONE DENSITY SCAN

What is your weight?_____

What is your height? _____ Have you lost height?_____

Race: ☐ Afro-American ☐ White ☐ Native American ☐ Asian ☐ Other_____

Sex: ☐ Female ☐ Male

Have you had previous Bone Density Scans? ☐ Yes ☐ No

If yes: When and Where?_____

Have you had any of the following conditions? (check Y or N)	Yes	No
Osteoporosis	☐	☐
If Yes, are you currently being treated and if so with what medication? _____		
Kidney disease	☐	☐
Hyperthyroidism (overactive thyroid)	☐	☐
Hyperparathyroidism	☐	☐
Family history of osteoporosis	☐	☐

Have you taken any of the following medications? (check Y or N)	Yes	No
Anticonvulsants (for seizure,epilepsy)	☐	☐
Steroids (prednisone,cortisone)	☐	☐
Hormones	☐	☐

Have you gone through menopause?	☐	☐
If yes, at what age?_____		
Have you fractured any bones during your adult life?	☐	☐
If yes, where?_____		
Have you ever had surgery on your hips or spine ?	☐	☐
If yes, what surgery?_____		
Have you ever had ovarian or uterine surgery?	☐	☐
If yes, what surgery?_____		

Please list any doctors names and addresses you would like to receive the report of your scan.

_____

_____

Patient Signature:_____Date:_____