SUN VIEW
IMAGING SERVICES

BONE DENSITOMETRY
PATIENT HISTORY

NAME:_____ DATE:_____

DOB:_____ AGE:_____ HT:_____ WT:_____

REFERRING DR:_____ MD

MALE ☐ FEMALE ☐

RACE: AFRICAN AMERICAN ☐ ASIAN ☐ CAUCASIAN ☐ HISPANIC ☐ OTHER ☐

PLEASE CHECK AND GIVE DETAILS WHERE NECESSARY:

Pregnancy Status: ☐Yes ☐No Which is your dominant side (hand)? ☐RT ☐ LT

Is this your first bone density exam? ☐Yes ☐No

Have you had a contrast (barium) or Nuclear Medicine (isotope) exam in the last 7 days? ☐Yes ☐No

Have you had hip replacement surgery? ☐Yes ☐No Which Side? Right_____ Left_____

Do you have a curvature of the spine (scoliosis)? ☐Yes ☐No

Have you had low back surgery? ☐Yes ☐No What procedure? _____

Is there family history of osteoporosis? ☐Yes ☐No Which family member?_____

Have you ever taken any of the following medications: (Please Check)

—— Fosamax	—— Actonel	—— Cortico Steroids (Prednisone, etc.)
—— Evista	—— Estrogen	—— Miacalcin
—— Forteo	—— Calcium	—— Boniva

DO YOU HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS: (PLEASE CHECK)

____HYPERTHYROIDISM	____HYPERPARATHYROIDISM	____RHEUMATOID ARTHRITIS
____HYSTERECTOMY	____ASTHMA OR EMPHYSEMA	____ANY SEIZURE DISORDERS
____CANCER	____ANOREXIA OR BULIMIA	____INFLAMMATORY BOWEL DISEASE
____POST MENOPAUSAL		

I UNDERSTAND THAT SOME ELECTIVE STUDIES THAT UTILIZE X-RAYS SHOULD NOT BE PERFORMED ON WOMEN WHO ARE PREGNANT. TO THE BEST OF MY KNOWLEDGE, I AM NOT PREGNANT AND DO NOT THINK I COULD BE PREGNANT.

_____ _____

Signature Date

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Patient Medical History

PATIENT'S NAME _____ X-RAY # _____

AGE _____ REFERRING PHYSICIAN _____

RADIOLOGIST _____ TECHNOLOGIST _____

EXAM REQUESTED _____ ISOTOPE _____

PREVIOUS ☐ X-Rays ☐ Scans ☐ CT ☐ MRI ☐ Ultrasound (CHECK ALL THAT APPLY)

WHEN? _____ WHERE? _____

RESULTS OF PREVIOUS STUDIES: _____

_____

_____

PATIENT COMPLAINTS/SYMPTOMS OR REASON FOR EXAM: _____

_____

_____

_____

PREVIOUS MEDICAL HISTORY: _____

_____

_____

PREVIOUS SURGERY: _____

_____

WHEN ? _____ WHERE? _____

UNDERSTAND THAT SOME ELECTIVE STUDIES THAT UTILIZE X-RAYS SHOULD NOT BE PERFORMED ON WOMEN WHO ARE PREGNANT. TO THE BEST OF MY KNOWLEDGE, I AM NOT PREGNANT AND DO NOT THINK I COULD BE PREGNANT.

PATIENT SIGNATURE: _____

DATE: _____ FLUORO TIME: _____