

PARK WEST RADIOLOGY

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: / /