

# LENOX HILL RADIOLOGY & MEDICAL IMAGING ASSOCIATES P.C.

## 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:    /    /