DOCTORS GROOVER
CHRISTIE & MERRITT
RADIOLOGISTS

Advancing Medical Imaging Since 1916

Bone Density Scan Questionnaire

Date: ______________________

Patient Name: _____________________________ Age: _________________

Previous bone density scan: Yes _____ No _____ When/where: ___________

Are you pregnant? Yes _____ No _____ LMP ______________________

Please check one of the following:

Pre-menopausal_____ Peri-menopausal_____ Post-menopausal_____

Have you been diagnosed with osteoporosis? Yes______ No_____

Are you taking long term **steroid** medications or other medications that cause osteoporosis? (please specify): _____________________________________

Do you have a history of any of the following? (please check all that apply):

Hyperparathyroidism ___ Cushing's Syndrome___ Premature Menopause ___

Turner's Syndrome, XO Syndrome, Gonadal dysgenesis___

Ovarian Failure: (due to radiation or chemotherapy) ___ (cause unknown)___

Have you had any x-ray studies or nuclear medicine test done in the last month? ____ If yes, please specify. ____

Do you have any history of fractured bones in the hip, neck, back, sacrum/coccyx, or forearm? _____ If yes, please specify _________________________________

Have you had hip replacement? _____ If yes, which hip? ___________________

Are you right or left handed? ____

Do you know why you are having this test? If yes, please specify
____

Technologist: ______________________