TRI-CITY RADIOLOGY

BONE DENSITY IMAGING EVALUATION FORM

Please help us evaluate your problem by completing this form **Today's Date:** _____

NAME: _____ **Age:** _____ **Weight**_____

List any medications you take on a regular basis _____

_____

Yes No Have you ever had any broken bones as an adult?
Which bones _____ Age: _____

Yes No Have any of your blood relatives been diagnosed with osteoporosis?

Yes No Have you had a bone density test before?
Where: _____ Date: _____

Present Height _____ Maximum Height _____

******Female Patients Only******

Yes No Are you having menstrual periods?
If they have stopped, how old were you when they stopped? Age: _____

Yes No Have you had a hysterectomy? Age: _____

Yes No Were your ovaries removed? Age: _____

_____

****Technologist Notes****

Reason for test: Routine _____ Other_____

Technical Difficulties

_____

_____ Baseline Scan _____ Comparison Scan Tech_____