The Bristol Radiology Center
25 Collins Rd Bristol, CT 06010

Bone Densitometry

Patient History form

Name_____ Date of Birth_____

Doctor_____ Today's Date_____

Race_____ Med Rec Number_____

Have you broken any bones after the age of 40? (Excluding hands and feet) **Y** **N**
If yes, which one(s)?_____

Is there a family history of osteoporosis? **Y** **N**
Whom?_____

Does your mother or father have a history of hip fracture? **Y** **N**

Have you had this exam before? **Y** **N**

Have you been diagnosed with any of the following? Please check all that apply

Osteoporosis/osteopenia _____ Type I diabetes(Insulin dependent)_____
Osteogenesis Imperfecta _____ Hypogonadism_____
Untreated long standing hyperthyroidism_____ Malabsorbtion_____
Premature menopause(<45 yrs old)_____ Chronic malnutrition_____
Chronic liver disease _____ Rheumatoid arthritis_____

Have you taken steroids (cortisone) for more than 3 months at a dose of 5 mg or more? **Y** **N**

Do you drink 3 or more units of alcohol daily? **Y** **N**

Do you currently smoke tobacco? **Y** **N**

Have you had a hysterectomy? **Y** **N**

Age of menopause _____

Are you using hormones? **Y** **N**

Do you take Calcium/ Vitamin D/ Strontium supplements? **Y** **N**

Please circle the medications you presently take: How long have you been taking? _____

Miacalcin(Calcitonin) Fosamax Evista Actonel Boniva Prolia Atelvia

Alendronate Bisphosponate Forteo Fortical Reclast Zometa Diphosphonate

_____
Patient's Signature

Thank You

for office use only

Height:_____

Weight:_____