Bone Densitometry Patient Form

The Bristol Radiology Center
25 Collins Road
Bristol CT, 06010
(860) 584-0541

Name:_____ Date of Birth:_____

Referring Doctor:_____ Todays's Date:_____

Prior Bone Density Examinations:	Y		N
Prior Diagnosis of Osteoporosis:	Y		N
Prior Fractures:	Y		N
Back Pain:	Y		N
Do you Take Steroids?	Y		N
Hysterectomy:	Y		N
Thyroid Problems:	Y		N
Smoking History:	Y		N
Circle the medications you take:	Fosomax	Actonel	Evista
Any possibility of pregnancy?	Y		N

Patient signature:_____

For office use only:

Height:
Weight: