TRI-CITY RADIOLOGY

DEXA - BONE DENSITY Imaging Evaluation Form

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

List any medications you take on a regular basis _____

_____

Have you ever had any broken bones as an adult? **YES** or **NO**

If yes, which bones? _____

Your age when this occurred: _____

Have any of your blood relatives been diagnosed with osteoporosis? **YES** or **NO**

Have you had a bone density test before? **YES** or **NO**

- If yes, where was this completed? _____
- Date of prior DEXA scan: _____

Present Height: _____ Maximum Height: _____

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

Are you having menstrual periods? **YES** or **NO**

- If they have stopped, **how old were you when they stopped**? Age: _____

Have you had a hysterectomy? **YES** or **NO** Age: _____

Were your ovaries removed? **YES** or **NO** Age: _____

****Technologist Notes****

Reason for test: Routine ____ Other_____

Technical Difficulties: _____

_____ Baseline Scan _____ Comparison Scan Tech_____