Bone Density Questionnaire

PENRAD IMAGING
Life. Well seen.

Patient Name: _____ Date: _____

Referring Provider: _____ Date of Birth: _____

Patients should not ingest calcium or calcium supplements 24 Hours prior to exam

Have you had a barium X-Ray test within the last week? Y N

Are you being treated for Osteoporosis/Osteopenia? Y N

Have you been diagnosed with Osteoporosis/Osteopenia? Y N

Gender M F

What was your maximum height? _____

Are you Premenopausal? Y N Are you Pregnant? Y N

Are you taking hormone replacements? Y N Are you Postmenopausal? Y N

Age during menopause? _____

Have you had your ovaries removed? Y Right Left Both N

Previous Bone Density Study Y N Osteonecrosis ***(bone death)*** Y N

Malunion or Nonunion of Fracture Y N Current Smoker Y N

Non-Traumatic Fracture or Stress Fracture Y N Hyperparathyroid Disease Y N

History of Previous Hip/Vertebral Fracture Y N Rheumatoid Arthritis Y N

History of Hip Fracture in Parents Y N Vitamin D Deficiency Y N

Surgery on Back or Either Hip Y N Steroids (Prednisone) Y N

Current use of Steroids ☐ *Inhaled* ☐ *Injected*

Past use of Steroids ☐ *Inhaled* ☐ *Injected*

Prolia Y N **How Long?** _____

Evista/Raloxifene Y N **How Long?** _____

Calcitonin (Miacalcin, Calcimar, Fortical) Y N **How Long?** _____

Fosamax (Alendronate), Actonel, Forteo, Boniva, Reclast Y N **How Long?** _____

Alcohol – more than 3 glasses per day Y N **How Long?** _____

For Staff Use Only:

Height: _____ Weight: _____ ABN Y N

Tech Notes/Initials: _____ Account # _____

(719) 785-9000
877-6-PENRAD • (877) 673-6723
PENRAD.org