PATIENT INFORMATION SHEET FOR BONE DENSITY TEST

Osteoporosis is a bone weakening disease that makes bones prone to fracture and effects predominantly women. One in six women will suffer a hip fracture during their lifetime and one in four will suffer a collapsed vertebrae. At menopause, a woman begins losing bone strength at a rate of three to five percent each year. This, however, can be prevented. The DEXA machine can determine a woman’s baseline density as she enters menopause. This is the best measurement to assess one’s risk factor. When a low bone density is detected, lifestyles changes and possible medications can slow bone loss by helping to prevent fractures and/or spinal collapse.

The test is painless and takes less than an hour. DEXA scanners use very low doses of radiation to measure bone mass. There is less radiation in 20 bone scans than in one mammogram.

On the day of the test do not eat or take any calcium prior to the test. You must weigh less than 300 pounds and the test cannot be done if you are pregnant. No barium or nuclear studies should have been done within seven days prior to the test. For your ease and comfort, please wear a two piece outfit and avoid zippers, buttons and buckles.

Please check with your insurance company to determine if you need a referral number or any special information. Please bring your doctor’s order with you. You may fill out the questionnaire prior to the appointment, or if you need assistance we will help you prior to testing.

Appointment: _________________________________________________________________________

Day    Date    Time

Patient Name: ________________________________________________________________
Please Answer all of the questions below and bring back to appointment

Name: __________________________________________________________
Date of Birth: ____________________________________________________
Zip Code: ______________________________________________________
Doctor: _________________________________________________________

Gender: Male  Female

Is there any chance you may be pregnant?  Yes  No
Ethnicity: Black White Hispanic Asian Other

Height: ____________ Weight: ____________ Eye Color: _________ Natural Hair Color: _____________

Build: Small Average Large

Are you post-menopausal (no longer having menstrual cycle)?  Yes  No
If yes, at what age did menopause occur? ________________
Have you had a hysterectomy?  Yes  No
Partial or complete, at what age was this done? ________________
Are you on any hormones? If Yes, how many years? ________________

Do you take calcium supplements?  Yes  No
Are you taking any long term (3 months or longer) steroids?  Yes  No
Have you ever taken steroids for 3 months or longer?  Yes  No

Please list medications that you are currently taking:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Have you ever had a Bone Density done before?  Yes  No
If yes, Where: ________________________________________ When: ___________________________

Are you right or left handed? Right Left

Have you ever had a hip fracture or replacement surgery ( Left  or  Right )  Yes  No
Have you ever had surgery on your lower back?  Yes  No
If yes, which vertebrae? ________________

Have you ever had a spine fracture  Yes  No

Please list any fractures (broken bones) you have had: ______________________________________

Do you have a known curvature (scoliosis) of your spine?  Yes  No

Have you had any examination within the past 7 days where you were injected or given something to
drink for the test? Example Barium or Nuclear Medicine  Yes  No
If yes, please list type of test: ___________________________________________________________

Do you have any family history of osteoporosis?  Yes  No
Do you have any history of Rheumatoid Arthritis?  Yes  No
Have you noticed any decrease in your height?  Yes  No
Do you exercise regularly?  Yes  No
Do you drink caffeinated coffee, tea or cola? (Circle all that apply)
Do you drink any alcoholic beverages?  Yes  No
If yes, how many per day? ________________

Do you smoke?  Yes  No
Have either of your parents ever had a broken hip in their lifetime?  Yes  No

Do you have Diabetes (on Insulin), Hyperthyroidism, Hypergonadism, premature Menopause (less than 45 year old), chronic malnutrition, or chronic liver disease? (Circle all that apply)

Patient Signature: __________________________________________________________________

Technologist Signature: _______________________________________________________________