KRC
KENOSHA RADIOLOGY CENTER

BONE DENSITOMETRY

Name:_____ Today's Date_____

Date of Birth:_____Age____ Height: _____Weight:_____

Sex: Female ☐ Male ☐ Referring Physician:_____

Medical History:	Yes	No
1. Have you ever taken any hormone replacements? What years?_____	☐	☐
2. Have you ever had a bone density test? When and where?_____	☐	☐
3. Have you ever been treated for osteoporosis or weak bones? What years?_____ What medicines?_____	☐	☐
4. Have you had any x-ray studies with Barium or contrast or nuclear medicine studies in the past week?	☐	☐
5. Have you taken any of the following medications for more than one year? a. Steroids (prednisone, cortisone, etc.) b. Thyroid Medication	☐ ☐	☐ ☐
6. Do you take calcium supplements? Have you had any in the past 48 hours?	☐ ☐	☐ ☐
7. *For female patients only*: Do you menstruate? If no: Because of menopause? When? _____ Because of removal of ovaries? When?____ Because of removal of just the uterus? Because of chemotherapy? When?____	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐

Technologist Notes: ☐ Small Block ☐ Medium Block ☐ Tall Block