



BONE DENSITOMETRY INTAKE FORM

Please print legibly

Date: ___ / ___ / ___ Name: Last Name First Name Middle Initial

Date of Birth: ___ / ___ / ___ Age Height Weight SS#: _____

Referring Physician: _____

CC: _____

CC: _____

Is there any chance that your may be pregnant now? [] Yes [] No

Have you taken any calcium supplements in the past 24 hours? [] Yes [] No

Have you had a barium exam in the past 2 weeks? [] Yes [] No

Is this your first bone densitometry? [] Yes [] No
If not, when/where was it performed? _____

Are you receiving any therapy for osteoporosis? [] Yes [] No
If yes, please list _____

Are you currently taking any medication in addition to above? [] Yes [] No
If yes, please list _____

Is there a family history of osteoporosis? [] Yes [] No
If yes, please indicate _____

Have you had any fractures? [] Yes [] No
If yes, where and at what age? _____

If applicable, age at menopause? _____

Ethnicity: [] Caucasian [] Hispanic [] African American [] American Indian [] Asian [] Other Race

Patient Signature

Patient Name

Date