



Comprehensive Diagnostic Imaging & Radiology

BONE DENSITOMETRY QUESTIONNAIRE

MEDICAL RECORD NUMBER: _____

PATIENT NAME: _____

DATE OF BIRTH: _____

ORDERING PHYSICIAN: _____

HEIGHT: _____ WEIGHT: _____

AGE AT ONSET OF MENOPAUSE: _____

ETHNIC BACKGROUND (CIRCLE ONE):

CAUCASIAN HISPANIC AFRICAN AMERICAN ASIAN OTHER _____

DO YOU HAVE A HISTORY OF:

THYROID DISEASE: YES NO

BROKEN BONES: YES NO

IF YES WHICH: _____

ARTHRITIS: YES NO

IF YES WHERE: _____

OSTEOPOROSIS: YES NO

SCOLIOSIS: YES NO

ANY ORGANS REMOVED: YES NO

IF YES WHICH: _____

BACK SURGERY: YES NO

LIST ALL PRESCRIPTION MEDICATION TAKEN ON A REGULAR BASIS:

