

**BONE DENSITY
VALLEY IMAGING CENTER**

Please Print

Patient ID # _____

Date: _____

Ordering Physician: _____

Office Phone #: _____

Patient Name: _____ DOB: _____ Age: _____

Ethnicity (Please Circle): Asian African Hispanic Caucasian Other

Age of Menopause: _____ Height: _____ Weight: _____

Adult Fractures (Please Circle) Femur Forearm Humerus Pelvis Spine

Patient History (Please Check All That Apply)

- | | |
|--|---|
| <input type="checkbox"/> Older Than 65 Years of Age | <input type="checkbox"/> Hyperparathyroid |
| <input type="checkbox"/> Amenorrhea | <input type="checkbox"/> Hyperthyroid |
| <input type="checkbox"/> Anorexia Nervosa | <input type="checkbox"/> Hypothyroid |
| <input type="checkbox"/> Both Ovaries Removed | <input type="checkbox"/> Low Body Weight |
| <input type="checkbox"/> Smoke Cigarettes | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Poor/Frail Health |
| <input type="checkbox"/> Cushing's Syndrome | <input type="checkbox"/> Post Menopausal |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Recurrent Falls |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Early Menopause | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Family History Osteoporosis | <input type="checkbox"/> Sedentary |
| <input type="checkbox"/> Height Loss | |
| <input type="checkbox"/> Adult Fracture (Within 2 Yrs) | |

Medications (Please Check All That Apply)

- | | |
|--|------------------------------------|
| <input type="checkbox"/> Actonel | <input type="checkbox"/> Evista |
| <input type="checkbox"/> Anticonvulsants | <input type="checkbox"/> Forteo |
| <input type="checkbox"/> Calcitonin | <input type="checkbox"/> Fosamax |
| <input type="checkbox"/> Calcium | <input type="checkbox"/> Heparin |
| <input type="checkbox"/> Corticosteroids | <input type="checkbox"/> Lupron |
| <input type="checkbox"/> Depo Provera | <input type="checkbox"/> PTH 1-34 |
| <input type="checkbox"/> Estrogen | <input type="checkbox"/> Thiazide |
| | <input type="checkbox"/> Vitamin D |

For Office Use Only

Additional Information: _____

Technologist: _____