Send report to the following physicians:

Name: _____ Address: _____ Phone: _____

Name: _____ Address: _____ Phone: _____

Patient Information Questionnaire Bone Density Scans

Have you had a previous Bone Density Exam? ☐ No ☐ Yes Where? _____

What race are you? ☐ Asian ☐ Black ☐ Hispanic ☐ White ☐ Other _____

What is your tallest height? _____ What is your height today? _____ What is your weight? _____

Do you?

Take calcium supplements? ☐ No ☐ Yes

Smoke? ☐ No ☐ Yes

Have relatives with osteoporosis? ☐ No ☐ Yes

Are you taking?		**For About How Long?**
Medications for Osteoporosis:		
Actonel	_____	_____
Boniva	_____	_____
Forteo	_____	_____
Fosamax	_____	_____
Evista	_____	_____
Other _____	_____	_____
Hormone replacement (e.g. estrogen)	_____	_____

Have you had?

A fracture as an adult ☐ No ☐ Yes Specify: _____

Hip, spine or wrist surgery ☐ No ☐ Yes Specify: _____

Diabetes ☐ No ☐ Yes

For women only:

Have you reached menopause? ☐ No ☐ Yes If yes, when?: _____

Have you had breast cancer? ☐ No ☐ Yes Age or Year: _____

If yes, are you taking any of these (check if yes)?:

☐ Tamoxifen ☐ Arimidex ☐ Aromasin (exemestane) ☐ Femara

ROSE BREAST CENTER

Patient Information/Label

Bone Density

RADS
90026 (11/11)