Imaging
AUGUSTA UNIVERSITY HEALTH

Bone Density History

PATIENT INFORMATION

Fall Precaution ☐ YES ☐ NO

Last Name	First Name/Middle Initial	Gender	Race
Date of Birth (MM/DD/YYYY) / /	**Age**	**Height**	**Weight**

MEDICATIONS

List any current medications:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Do you take osteoporosis medication? ☐ YES ☐ NO If yes, what kind and how long? _____

Do you take Glucocorticoids? ☐ YES ☐ NO

PERSONAL HISTORY

Are you still having periods? ☐ YES ☐ NO

Drink more than 3 alcoholic drinks a day? ☐ YES ☐ NO

Are you a current smoker? ☐ YES ☐ NO

Has either parent had a hip fracture? ☐ YES ☐ NO

Have you ever had a fracture as an adult? ☐ YES ☐ NO

Do you have rheumatoid arthritis? ☐ YES ☐ NO

PRIOR IMAGING & SURGERIES

Any surgery to your hip or lumbar spine? ☐ YES ☐ NO

If yes, please explain: _____

In the last three days have you had a Barium x-ray, CT, or Nuclear Medicine Test? ☐ YES ☐ NO

If yes, please explain: _____

TECHNOLOGIST COMMENTS

_____ _____

TECHNOLOGIST SIGNATURE **DATE & TIME**