CHESAPEAKE MEDICAL IMAGING

Name:_____ **Date**:_____

Height:___ft ___in **Weight**: _____lbs **Age**:____ **Sex**: M or F

Ethnicity: (circle one) White Black Asian Hispanic Other

Have you had a Bone Density study before: Yes or No

If yes, name of facility:_____Date:_____

Have you had barium (for an x-ray test) in the last 2 weeks? YES or NO

Have you had a nuclear medicine scan or injection of dye/contrast in the last week? YES or NO

Have you had a calcium supplement (including tums) within the last 24 hours? YES or NO

FOR WOMEN ONLY Last Menstrual Cycle:_____ Menopause YES or NO

Check YES or NO to any of the following personal conditions:	**YES**	**NO**
Osteopenia (pre-osteoporosis)		
Osteoporosis		
Broken hip if yes R or L		
Hip Replacement if yes R or L		
Broken wrist if yes R or L		
Any other broken bones not listed above?		
Lower back/Spine Surgery		
Parent have a broken hip		
Rheumatoid Arthritis		
Currently Smoke		
Drink 3 or more glasses of alcohol per day		
Crohn's Disease		
Cancer if yes what type_____		
Hyperthyroid (over active)		
Hypothyroid (under active)		
Hyperparathyroid		
Hashimoto's Disease		
Diabetes		
Organ Transplant		

Have you been treated with any of the following medications:	**YES**	**NO**
Estrogen		
Progesterone		
Tamoxifen		
Arimidex		
Evista		
Testosterone		
Fosamax		
Actonel		
Aredia		
Boniva		
Vitamin D		
Calcium Supplement such as Caltrate or Tums		
Chemotherapy		
Steroids (glucocorticoids) 3 months or more		