Bone Density Form

Imaging Specialists

Today's Date: Sex: Male Female

Name: (Last) (First)

Height: Weight: Age: Race:

List Medications:

Have you ever fractured your hip, spine, or wrist as an adult? Yes or No

- If yes, when and which one:

Have you ever had surgery on your hip, spine, or wrist? Yes or No

- If yes, when and which one:

Do you drink 3 or more alcoholic beverages per day? Yes or No

Do you currently use tobacco? Yes or No

Do you have Rheumatoid Arthritis? Yes or No

Do you take Alendronate (Fosamax), Calcitonin, Prednisone or other steroids? Yes or No

- If yes, please circle which one and for how long?

Have either of your parents (mother or father) had a hip fracture? Yes or No

Signature Date