



BONE DENSITY EVALUATION

Name _____ Today's Date: _____ MR# _____

D.O.B. _____ Height: _____ Weight: _____ Race _____

Have you had nuclear medicine exam, X ray, CT or MRI contrast in the last 2 weeks? _____

Have you had surgery to your Hips or Lower spine? _____

When was your last menstrual period? _____ Are you pregnant? _____

Do you have any risk factors for Osteoporosis?

Do you have a family History of Osteoporosis? _____ Do you have a small frame/low body weight _____

Have you had fractures caused by minimum trauma? _____ Do you smoke? _____

Have you had a loss of height? _____ Are you sedentary (inactive)? _____

Do you have hyperparathyroidism? _____ other (please explain) _____

Are you taking any of the following medications?

Steroids (Prednisone, Cortisone, etc) _____ Thyroid Medication _____

Arimidex, Tamoxifen, Femara or Aromasin _____ Other _____

Are you taking medication for prevention of osteoporosis?

Calcium/Vitamin D Supplements _____ Calcitonin (Calcimar, Miacalcin) _____

Alendronate (Fosamax) _____ Raloxifene (Evista) _____

Actonel _____ Boniva _____

Forteo _____

Estrogen Replacement Therapy _____ Other _____

Patient Signature: _____ Date: _____

----- Do not write below this line -----

PRESENT BMD

Spine _____ gm/cm²

Neck Mean _____ gm/cm² R hip _____ gm/cm²

L hip _____ gm/cm²

Total Mean _____ gm/cm² R hip _____ gm/cm²

L hip _____ gm/cm²

PREVIOUS BMD FACILITY _____ DATE _____

Spine _____ gm/cm²

Neck Mean _____ gm/cm² R hip _____ gm/cm²

L hip _____ gm/cm²

Total Mean _____ gm/cm² R hip _____ gm/cm²

L hip _____ gm/cm²

PRESENT T-score

Spine _____

Neck Mean _____ R hip _____ L hip _____

Total Mean _____ R hip _____ L hip _____

PREVIOUS T-score

Spine _____

Neck Mean _____ R hip _____ L hip _____

Total Mean _____ R hip _____ L hip _____

IMPRESSION:

() High BMD () Normal () Osteopenia () Osteoporosis () Severe Osteoporosis

Notes:

Radiologist: (Please circle) BM SS OR Date _____