516 West Atlantic Street
South Hill, VA 23970
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PATIENT INFORMATION SHEET FOR BONE DENSITY TEST

Osteoporosis is a bone weakening disease that makes bones prone to fracture and effects predominantly women. One in six women will suffer a hip fracture during their lifetime and one in four will suffer a collapsed vertebrae. At menopause, a woman begins losing bone strength at a rate of three to five percent each year. This, however, can be prevented. The DEXA machine can determine a woman's baseline density as she enters menopause. This is the best measurement to assess one's risk factor. When a low bone density is detected, lifestyles changes and possible medications can slow bone loss by helping to prevent fractures and/or spinal collapse.

The test is painless and takes less than an hour. DEXA scanners use very low doses of radiation to measure bone mass. There is less radiation in 20 bone scans than in one mammogram.

On the day of the test do not eat or take any calcium prior to the test. You must weigh less than 300 pounds and the test cannot be done if you are pregnant. No barium or nuclear studies should have been done within seven days prior to the test. For your ease and comfort, please wear a two piece outfit and avoid zippers, buttons and buckles.

Please check with your insurance company to determine if you need a referral number or any special information. Please bring your doctor's order with you. You may fill out the questionnaire prior to the appointment, or if you need assistance we will help you prior to testing.

Appointment: _____
Day Date Time

Patient Name: _____

Please Answer all of the questions below and bring back to appointment

Name: _____
Date of Birth: _____
Zip Code: _____
Doctor: _____
Gender: Male Female
Is there any chance you may be pregnant? Yes No
Ethnicity: Black White Hispanic Asian Other
Height: _____Weight: _____ Eye Color: _____ Natural Hair Color: _____
Build: Small Average Large
Are you post-menopausal (no longer having menstrual cycle)? Yes No
If yes, at what age did menopause occur? _____
Have you had a hysterectomy? Yes No
Partial or complete, at what age was this done? _____
Are you on any hormones? If Yes, how many years? _____ Yes No
Do you take calcium supplements? Yes No
Are you taking any long term (3 months or longer) steroids? Yes No
Have you ever taken steroids for 3 months or longer? Yes No
Please list medications that you are currently taking:
_____
_____
_____+_____

Have you ever had a Bone Density done before? Yes No
If yes, Where: _____ When: _____
Are you right or left handed? Right Left
Have you ever had a hip fracture or replacement surgery (Left or Right) Yes No
Have you ever had surgery on your lower back? Yes No
If yes, which vertebrae? _____
Have you ever had a spine fracture Yes No
Please list any fractures (broken bones) you have had: _____
Do you have a known curvature (scoliosis) of your spine? Yes No
Have you had any examination within the past 7 days where you were injected or given something to drink for the test? Example Barium or Nuclear Medicine Yes No
If yes, please list type of test: _____
Do you have any family history of osteoporosis? Yes No
Do you have any history of Rheumatoid Arthritis? Yes No
Have you noticed any decrease in your height? Yes No
Do you exercise regularly? Yes No
Do you drink caffeinated coffee, tea or cola? (Circle all that apply)
Do you drink any alcoholic beverages? Yes No
If yes, how many per day? _____
Do you smoke? Yes No
Have either of your parents ever had a broken hip in their lifetime? Yes No
Do you have Diabetes (on Insulin), Hyperthyroidism, Hypergonadism, premature Menopause (less than 45 year old), chronic malnutrition, or chronic liver disease? (Circle all that apply)

Patient Signature: _____

Technologist Signature: _____