

**NYU CLINICAL CANCER CENTER
DIAGNOSTIC IMAGING
160 E. 34th Street
New York, New York 10016**

Patient label

BONE DENSITOMETRY SCREENING

PATIENT NAME:	DATE OF BIRTH: / /	AGE:
REFERRING PHYSICIAN:	PHONE #:	

Is this your first Bone Density study? <input type="checkbox"/> YES <input type="checkbox"/> NO If NO, when and where was your last test completed:
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<p>*Ethnic background:</p> <p><input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Other</p> <p>*Asian and Caucasian women have the highest risk for developing osteoporosis. African-American and Hispanic women have a lower but still significant risk.</p>
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Date of last menstrual period: / /	Could you be pregnant? <input type="checkbox"/> YES <input type="checkbox"/> NO
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Current Weight:	Height:	Age at Menopause:
Are you taking hormone replacement? <input type="checkbox"/> YES <input type="checkbox"/> NO		Specify:

List current medications:

Do you have any of the following?			
Asthma	<input type="checkbox"/> YES <input type="checkbox"/> NO	Thyroid Disorder	<input type="checkbox"/> YES <input type="checkbox"/> NO
Kidney Disorder	<input type="checkbox"/> YES <input type="checkbox"/> NO	Scoliosis	<input type="checkbox"/> YES <input type="checkbox"/> NO
Previous fractures	<input type="checkbox"/> YES <input type="checkbox"/> NO		
If yes, list body part and approximate date?			
Do you take calcium supplements?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Did you take any today?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, how much daily?	<input type="checkbox"/> 0-500 mg	<input type="checkbox"/> 500-1000 mg	
Do you use dairy products?	<input type="checkbox"/> YES <input type="checkbox"/> NO		
If yes, what and how much daily?			
Do you have a family history of osteoporosis?	<input type="checkbox"/> YES <input type="checkbox"/> NO		

Were you ever a smoker? <input type="checkbox"/> YES <input type="checkbox"/> NO If you stopped, when?

I verify that the answers I have provided to the questions on this form are correct and understand that withholding information or inaccurate information may adversely affect the interpretation of this exam.

Patients signature:	Date: / /
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Technologist comments:

Technologist initials:	Date: / /
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