



# FREDERICK RADIOLOGY

## Diagnostic Center

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Patient Name: \_\_\_\_\_ Exam Date: \_\_\_\_\_  Female  Male

Age: \_\_\_\_\_ Weight: \_\_\_\_\_ LBS Height: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

### FOR OFFICE USE ONLY

Measured Weight \_\_\_\_\_ LBS. Measured Height: \_\_\_\_\_ Technologist: \_\_\_\_\_

PLEASE COMPLETE THE FOLLOWING QUESTIONNAIRE. If you answer YES to the first two questions below, do not continue with this questionnaire. Return all forms to the receptionist, and a technologist will speak to you shortly.

- Y  N Are you or do you suspect that you are pregnant?
- Y  N Have you had any exam using ingested barium within the past 7 days?

### HISTORY

- Y  N Have you had a DXA (Bone Density) scan in the past? When? \_\_\_\_\_ Where? \_\_\_\_\_
- Y  N Prior surgery to your hip(s) or spine? If yes, Please explain. \_\_\_\_\_
- Y  N Do you have Hyperparathyroidism?

For Female patients only:

- Y  N Have you gone through menopause? If yes, at what age? \_\_\_\_\_

### RISK FACTORS FOR OSTEOPOROSIS

- Y  N Loss of height? If yes, your height as a young adult: \_\_\_\_\_
- Y  N Family history of Osteoporosis?
- Y  N Has either biological parent had a broken hip?
- Y  N Have you fractured a bone since the age of 40, other than hands, feet or skull? \_\_\_\_\_
- Y  N Do you currently smoke cigarettes?
- Y  N Do you have more than 2 drinks of alcohol per day?
- Y  N Have you taken daily steroids (i.e. prednisone) for 3 or more months?
- Y  N Do you have a condition known to be associated with bone loss (i.e. diabetes, absorption disorder, premature menopause)? If yes, what: \_\_\_\_\_
- Y  N Have you been diagnosed with rheumatoid arthritis? (Not Osteoarthritis)
- Y  N Vitamin D deficiency?
- Y  N Stomach bypass or band surgery?

### CURRENT MEDICATIONS

- Y  N Calcium and/or Vitamin D supplements?
- Y  N HRT (Hormone Replacement Therapy)?
- Y  N Anticonvulsants (seizure medications)? If yes, name or medication: \_\_\_\_\_
- Y  N Thyroid medication. If yes, name of medication: \_\_\_\_\_
- Y  N DepoProvera
- Y  N Prescription medication for osteopenia or osteoporosis. If yes, how long? \_\_\_\_\_

Check All Medications that Apply:

- Fosamax  Actonel  Miacalcin  Boniva  Evista  Reclast  Other: \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Technologist