TOWER IMAGING
MEDICAL · GROUP
Imaging by Specialists

23929 McBean Parkway, Suite 109
Valencia, California 91355
TEL: (661) 753-5400
FAX: (661) 753-5401

BONE DENSITY SCREENING

Name: _____ Height; ____'_____" Weight: _____lbs

Have you entered Menopause?	❑ Yes	❑ No	If Yes, what age? _____
Have you had a Hysterectomy?	❑ Yes	❑ No	
Were your Ovaries removed?	❑ Yes	❑ No	If Yes, ❑ One ❑ Both
Are you taking Osteoporosis medication?	❑ Yes	❑ No	Name of Medication: _____
Are you taking Hormone replacements?	❑ Yes	❑ No	(premarian, estrogens etc.) _____
			_____
Do **you** have a history of Cancer?	❑ Yes	❑ No	
Are you taking Oral Steroids?	❑ Yes	❑ No	How long? _____
			(longer than 3 months
Do you smoke Cigarettes?	❑ Yes	❑ No	How much per day? _____
Do you drink Alcohol?	❑ Yes	❑ No	If yes, how much per day? _____
Family history of Osteoporosis?	❑ Yes	❑ No	If Yes, who? _____
Adult Compression Spine Fractures?	❑ Yes	❑ No	
Any previous Adult Hip Fractures / Replacements?	❑ Yes	❑ No	If Yes, which side: ❍ Right ❍ Left
Did your Mother or Father have a Hip Fracture?	❑ Yes	❑ No	❍ Mother ❍ Father
Do you have a confirmed diagnosis of Rheumatoid Arthritis?	❑ Yes	❑ No	

Do you have any of the following disorders associated with Secondary Osteoporosis:

❑ Type 1 Diabetes ❑ Osteogenesis Imperfecta ❑ Hyperthyroidism
❑ Hypogonadism ❑ Premature Menopause (less than 45yrs) ❑ Malabsorption
❑ Chronic Liver Disease ❑ Chronic Malnutrition

In the last week have you had:

❑ Nuclear medicine exam ❑ Contrast-media ❑ Barium Enema
❑ Upper GI ❑ Cat Scan ❑ MRI

Technologist Notes: