

Herspace Breast Imaging Associates

187 Highway 36, MPCC I, BLDG A, SUITE 130 West Long Branch, NJ 07764,
TELEPHONE (732) 571-9100 FAX (732) 571-9650.

Account # _____ Tech _____ Date _____

BONE DENSITOMETRY QUESTIONNAIRE

Referring physician: _____

Name: _____

Age: _____ DOB: ____/____/____ Weight _____ lbs. Height ____ft____inches

1. Prior bone density study? Yes Date ____/____/____ Location: _____
No

2. Do you have a diagnosis of osteopenia/osteoporosis? Yes please circle No

3. Have you gone through menopause and if so, when? Yes When ? _____ No

4. Date of last menstrual period - ____/____/____

5. Are you pregnant? Yes No Unsure

(If "yes" or "unsure", please also inform the technologist. We will need to reschedule the test)

6. Have you had a nuclear medicine test performed within the last two weeks? Yes No

If "yes", please indicate what study, where and when: _____

7. Are you a smoker ? Yes No

8. Have you ever taken any medication for bone loss such as Fosamax, Actonel, Evista, miacalcin, Boniva, Forteo, other _____? Yes Please circle medication When? _____
No

9. Are you currently taking any medication for bone loss such as Fosamax, Actonel, Evista, miacalcin, Boniva, Forteo, other _____? Yes Please circle medication No

10. Have you taken any of the following in the last few years: steroids, thyroid medication, seizure medications, Lasix, Heparin, chemotherapy, Arimidex/Tamoxifen?
Yes ? Please circle medication When? _____ How long? _____ No

Continued on back

11. Do you have a history of any spine or hip implants, prostheses, fractures or surgery? Yes No

If "yes", please explain: _____

12. Have you ever had any other medical problems (parathyroid, liver, kidney, or bowel disease)? Yes No

If "yes", please describe _____

13. Do you have a family history of osteopenia/osteoporosis? Yes No Unknown