CENTER FOR FAMILY MEDICINE, P.A.

CHRISTIAN A. COOPER, M.D.
JASYN H. HANEY, M.D.
BRADLEY G. HODGE, M.D.
JAMES T. RUSSELL, M.D.
HELEN A. SCHULZE, M.D.
RONALD A. WOODS, JR., M.D.
Diplomates of the American Board of Family Practice

Rose Marr, NP
Karen Young, NP

1906 Highway 82 West • Sherman, Texas 75092
(903) 892-8398
Fax (903) 892-6665

BONE DENSITY INSTRUCTION FORM

INSTRUCTIONS: ON THE DAY OF YOUR BONE DENSITY SCAN, PLEASE DRESS IN COMFORTABLE CLOTHING THAT CONTAINS NO METAL CLIPS, PINS, ZIPPERS OR BUTTONS. WEAR SHOES THAT ARE EASILY REMOVABLE. DO NOT WEAR JEWELRY. DO NOT TAKE CALCIUM OR MULTIVITAMINS WITH CALCIUM 24 HOURS BEFORE APPOINTMENT.

1) NAME:_____ 2) TODAY'S DATE_____
3) GENDER (circle one) M or F 4) DATE OF BIRTH_____
5) ETHINICITY: (circle one) BLACK / WHITE / HISPANIC / ASIAN / OTHER
6) HEIGHT_____ 7) WEIGHT_____
8) EYE COLOR_____ 9) HAIR COLOR_____
10) BUILD: (circle one) SMALL / AVERAGE / LARGE
11) REFERRING DOCTOR: _____
12) SOCIAL SECURITY # _____
13) IS THERE ANY CHANCE THAT YOU MAY BE PREGNANT?(circle one) Y or N
14) DATE OF LAST MENSTRUAL PERIOD_____

15) HAVE YOU HAD THIS EXAMINATION BEFORE? (circle one) Y or N
IF SO, AT WHICH MEDICAL FACILITY? _____
WAS IT ON YOUR FINGER_____ OR ON THE TABLE_____

16) HAVE YOU HAD A HIP OR UPPER LEG SURGERY INVOLING METAL?
(circle one) Y or N
IF SO, WHICH HIP WAS IT PERFORMED ON? (circle one) RIGHT / LEFT / BOTH

17) HAVE YOU HAD ANY SURGERY ON YOUR LOWER BACK INVOLVING METAL PINS OR DISC FUSION? (circle one) Y or N
IF SO,WHICH PROCEDURE _____

18) DO YOU HAVE A KNOWN CURVATURE (scoliosis) OF YOUR SPINE?
(circle one) Y or N

19) HAVE YOU HAD ANY EXAMINATIONS WITHIN THE PAST 10 DAYS WHERE YOU WERE INJECTED OR INGESTED A CONTRAST MATERIAL, i.e.BARIUM ? IF SO, WHICH EXAM _____

20) DO YOU HAVE FAMILY HISTORY OF OSTEOPOROSIS? (circle one) Y or N

21) HAVE YOU HAD ANY FRACTURE (break) INVOLVING HIP, UPPER LEG, BACK OR FOREARM? YES _____ NO _____
EXPLAIN_____
_____

22) Are you post-menopausal? If so, at what age did menopause occur? _____
23) Do you take any medications? If so, please list:_____
_____
_____

24) Do you take calcium supplements? Including Tums. (circle one) Y or N If so how often?_____Did you take them this morning?_____

25) Have you had a hysterectomy? (circle one) Y or N AGE _____
(circle one) Partial or Complete. Year _____

26) Have you had a tubal ligation? (circle one) Y or N
27) Are you on hormone replacement therapy? (circle one) Y or N
28) Do you or have you taken corticosteroids? (circle one) Y or N
29) Do you exercise regularly? (circle one) Y or N
30) Do you drink alcohol? (circle one) Y or N
31) Do you smoke? (circle one) Y or N
32) Do you drink coffee? (circle one) Y or N
33)Do you have any medical condition involving the thyroid (Hyperthyroid; Hypothyroid or Thyroid surgery.) (circle one) Y or N If so please list: _____
_____

34) Have you had any medical testing which includes the use of barium or nuclear medications within the last 10 days? (circle one) Y or N If so, please list:_____
_____

I have read and filled out the above information and do consent to the bone density scan.

Patient signature:_____ Date: _____

Technologist signature: _____ Date: _____