BROADWAY IMAGING CENTER

Bone Density Questionnaire

1) Have you had any procedures using the following substances within the last 14 days?

   Iodine, barium o nuclear medicine isotopes: YES NO

2) Have you ever had lower back surgery? YES NO

3) Have you had hip surgery? YES NO

4) Are you taking any hormones? YES NO

5) Are you taking any thyroid medication? YES NO

6) Are you taking any steroid medication? YES NO

7) Are you right or left handed? RIGHT LEFT

8) What is your ethnicity?

   White Black Asian Hispanic

   Other (please specify)_____

9) What is your current weight? _____

10) What is your current height? _____

FOR FEMALE ONLY

11) Have you had a hysterectomy? YES NO AGE:_____

12) Have you gone through menopause? YES NO AGE:_____

13) Have your ovaries been removed? YES NO

14) Were you under 16 when your cycles started? YES NO

Signature of patient X_____ Date_____

If signed by a caregiver or other, please list the relationship & reason for signing. Example: Husband, Sister, etc. "patient unable to sign due to stroke."

Witnessed by staff X_____ Date_____

140 North Glendale Avenue ● Glendale, CA 91206 ● Tel: 818-548-0022 ● Fax: 818-548-8385
www.BroadwayImagingCenter.com