mom Mammos On the Move
at DESERT IMAGING

Bone Density Questionnaire

Castellano Lee Trevino MOM Agnes El Paso MOM Sandy Valley MOM Diane Laredo

Name: _____ **DOB:** _____ **SEX: F**____ **M**____

Referring Physician: _____

☐ YES ☐ No Is there a chance that you are pregnant?
☐ YES ☐ No Have you had a barium x-ray in the last 2 weeks?
☐ YES ☐ No Have you had a nuclear medicine scan or injection of an X-ray dye in the last week?
☐ YES ☐ No Did you take your calcium supplement today?
☐ YES ☐ No Have you had surgery of the spine or hips? _____

(If you answered 'yes' to any of the above, please, speak to the Technologist.)

Gynecologic History

☐ YES ☐ No Postmenopausal Age_____
☐ YES ☐ No Hysterectomy Were ovaries removed? ☐ YES ☐ No
☐ YES ☐ No Hormone Therapy Estrogen Premarin Testosterone
☐ YES ☐ No Have you ever taken Depa Provera?

Medical History

☐ YES ☐ No Family history of osteoporosis
☐ YES ☐ No Hip fracture in a parent
☐ YES ☐ No Curvature of the spine Dowager's hump or scoliosis
☐ YES ☐ No Bone fracture Which bone_____How_____
☐ YES ☐ No Have you ever had a Bone Density Test? When?_____Where?_____
☐ YES ☐ No Do you take thyroid medication? Hypothyroidism Hyperthyroidism
☐ YES ☐ No Hyperpa rathyroid ism
☐ YES ☐ No Cancer _____ Chemotherapy Radiation Both
☐ YES ☐ No Did you take medications for Prostate Cancer?_____
☐ YES ☐ No Low Testosterone (Men)
☐ YES ☐ No Dialysis
☐ YES ☐ No Bariatric Surgery
☐ YES ☐ No Malabsorption Problems (Crohn's Disease, Ulcer surgery, Ciliac, Pancreatitis)
☐ YES ☐ No Cortisone or Prednisone Rheumatoid arthritis Allergy
☐ YES ☐ No Depression
☐ YES ☐ No Calcium
☐ YES ☐ No Vitamin D
☐ YES ☐ No Do you take Boniva, Evista, Actonel, Fosamax, Boniva, Evista, Miacalcin, Prolia, Forteo, Aredia, Zometa, or Reclast? _____

Lifestyle

☐ YES ☐ No Currently smoke or Smoked for _____yrs
☐ YES ☐ No 3 or more alcoholic beverages a day
☐ YES ☐ No Weight bearing exercise (walking, running, weight lifting)
☐ YES ☐ No Calcium rich foods in your diet

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Bone Density Self Request Patient Consent

I, _____ am presenting myself to **Desert Imaging Services/MOM** as a **"Self-Request"** patient for a Bone Density examination. I have read and agree to the following:

1. I currently have a personal physician and understand that Desert Imaging Services will forward the Bone Density examination results to my physician.
2. Please forward my Bone Density examination results to my physician, _____.
   Physician Name
3. **I further agree and understand that as a self-requesting patient it is my responsibility to schedule an appointment and follow up with my physician, in a timely manner, regarding the findings detailed in my Bone Density results and comply with the recommendations made by my physician.**
4. I am aware that most health insurance companies offer coverage for a screening Bone Density examination at a rate of one (1) screening every two (2) years (732 days).
5. I am also aware that the Bone Density examination is for screening purposes, and I will select one (1) or more of the following reasons for having this screening Bone Density examination .

   ☐ An estrogen deficient woman at clinical risk for osteoporosis .

   ☐ An individual with vertebral abnormalities .

   ☐ An individual with hypothyroidism.

   ☐ An individual with a history of bone fractures.

   ☐ An individual who is receiving long-term glucocorticoid therapy.

   ☐ An individual who is being monitored to assess the response to or efficacy of an approved osteoporos is drug therapy .

_____ _____

Patient Signature Date

_____ _____

Staff Signature Date