MNAP Medical Solutions

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Bone Density Evaluation

This test must be scheduled at least 10 days after any IV or oral contrast.

Name		Date of Birth
Height	**Weight**	**Build** ☐ Small ☐ Average ☐ Large
Email		**Gender** ☐ Male ☐ Female

1. **Is there any chance you could be pregnant?**
   ☐ Yes ☐ No

2. **Date of your last menstrual period**

3. **Have you had this examination before?**
   ☐ Yes ☐ No If so, where and when

4. **Are you right or lefthanded?**
   ☐ Left ☐ Right

5. **Have you had any wrist surgeries?**
   ☐ Yes ☐ No If so, which one? ☐ L ☐ R
   Date

6. **Have you had a hip replacement surgery?**
   ☐ Yes ☐ No If so, which hip? ☐ L ☐ R
   Date

7. **Have you had surgery on your lower back?**
   ☐ Yes ☐ No
   If so, which procedure(s), where and when? Please list

8. **Do you have a known curvature (scoliosis, kyphosis, lordosis) of the spine?**
   ☐ Yes ☐ No

9. **Have you had any examinations in the last 10 days where you were injected or ingested a contrast medium, i.e. barium?**
   ☐ Yes ☐ No If so, which exam

10. **Do you have a family history of osteoporosis?**
    ☐ Yes ☐ No

11. **Do you take any medications?**
    ☐ Yes ☐ No If so, please list

12. **Are you postmenopausal?**
    ☐ Yes ☐ No
    Age at menopause

13. **Do you take calcium supplements?**
    ☐ Yes ☐ No

14. **Do you have a perceived height loss?**
    ☐ Yes ☐ No

15. **Do you take or have you ever taken corticosteroids?**
    ☐ Yes ☐ No

Patient Signature	Date
Technologist Signature	**Date**