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HEALTH TECHNOLOGIES®

HOW TO PREPARE FOR YOUR BONE DENSITY SCAN

- Wear a sweatshirt if possible. Do not wear any blouses or shirts with metal hooks, zippers, buckles, or snaps. Ladies, please wear a sports bra (without metal hardware) or no bra at all. Do not wear slacks or trousers with zippers, buttons or any other hardware.

- You should not have had a barium study, radioisotope injection, oral or intravenous contrast material from a CT scan, MRI, or nuclear medicine study within 7 days before your bone density scan.

- You may eat normally on the day of the exam, unless your physician instructs you otherwise.

- Avoid taking calcium supplements for 24 hours.

- Avoid taking the prescription drugs Fosamax, Actonel, Evista and Forteo 24 hours before your bone density scan.

- For safety reasons, you must be ambulatory - able to climb six stairs into the mobile unit.

- You may not weigh over 300 pounds.

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Bone Density Scan Worksheet

Patient Name: _____ Date of Birth: _____ Age: _____

Ordering Doctor Name: _____ Location: _____

Patient Race: (circle one) Caucasian (White) / African American / Native American / Asian / Hispanic

Weight: _____ Height: _____ Have you lost any height? Y / N if yes, how much? _____inch(es)

Please List ALL medications, including vitamins and Calcium Suppliments:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

7. _____ 8. _____ 9. _____

10. _____ 11. _____ 12. _____

Check any of the following that apply to you:

Patient History

- ☐ Osteoporosis
- ☐ Cushing's Syndrome
- ☐ Cancer
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Parathyroid Disease
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Paget's Disease
- ☐ Rheumatoid Arthritis
- ☐ Family history of Osteoporosis
- ☐ Back pain (circle) Low / Middle / Neck
- ☐ Surgery on back Low / Middle / Neck
- ☐ Hip pain (circle) Right / Left / Both
- ☐ Surgery on hip Right / Left / Both
- ☐ Steroid Use/Therapy/Treatment?
  If checked, duration _____ days / _____ months / _____ yea
- ☐ Broken Bones (as an adult)
  if checked, how and which bones? _____

Patient Habits

Dairy Servings _____ per day (Milk, Yogurt, Cheese, Ice Cream, Butter etc.)

Caffeine Servings _____ per day (Coffee, Tea, Soda, Chocolate etc.)

Alcohol: (circle one) Never / Rarely / Occasionally / Daily

Smoking: No / Yes If yes, amount: _____ packs per day x _____Years

If no, Have you ever? No / Yes Years since quitting? _____

Exercise: No / Yes

If yes, how frequently? Daily / _____ days a week / _____ days a month

**********FOR WOMEN ONLY**********

Menstruation started at age _____ Menstrual Cycle: (circle one) Regular / Irregular

Hysterectomy? No / Yes If yes, age _____ (circle one) Partial / Complete

Menopause? No / Yes If yes, age _____

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Patient Authorization - Signature Required Prior to Procedure

I authorize the release of any medical or other information necessary to process this claim.
I also request payment of government benefits either to myself or to the party who accepts assignment below.

X Date:

Signature : Patient (Parent or Legal Guardian)

**********For Technologist Only**********

Technologist: _____ Scanner: _____ Ordering Diagnosis: _____