

O'SULLIVAN RADIOLOGY

Breast, Bone & Body Digital Imaging
6915 N. Main St., Victoria, Texas 77904
361-572-3139 fax 361-572-8610

Bone Density

DOLV _____

DATE _____

DOB _____

FILM# _____

NAME: _____

AGE: _____

PHYSICIAN(S) TO RECEIVE REPORT: _____

MARK ANY THAT APPLY:

BASELINE STUDY (1st bone density) _____
FOLLOW-UP STUDY _____
FAMILY HISTORY (osteoporosis) _____
PARENT WITH A HIP FRACTURE _____
PREVIOUS FRACTURE AS ADULT _____
HEIGHT IF KNOWN _____
HEIGHT LOSS _____
KYPHOSIS (forward curvature of spine) _____
SCOLIOSIS (sideways curvature of spine) _____
CURRENTLY SMOKING _____
DRINK 3 OF MORE ALCHOLIC
BEVERAGES DAILY _____
TAKE STEROIDS (cortisone,
hydrocortisone, prednisone,
methylprednisolone, triamcinolone,
dexamethasone, or betamethasone) _____
CALCIUM _____
BISPHOSPHONATES (Fosamax, Actonel,
Evista, Forteo, Miacalcin) _____
POST MENOPAUSAL _____
AGE AT MENOPAUSE _____
REPLACEMENT HORMONES _____
LAST MENSTRUAL PERIOD _____

**** DO NOT TAKE THIS X-RAY IF YOU MAY BE PREGNANT ****

HAVE YOU BEEN DIAGNOSED BY A DOCTOR FOR ANY OF THE FOLLOWING:

RHEUMATOID ARTHRITIS	YES	NO
TYPE 1 DIABETES	YES	NO
UNTREATED HYPERTHYROIDISM	YES	NO
CHRONIC MALNUTRITUION	YES	NO
CHRONIC LIVER DISEASE	YES	NO
OSTEOGENESIS IMPERFECTA (BRITTLE BONES)	YES	NO

FOR TECHNOLOGIST USE ONLY:

WEIGHT: _____

HEIGHT: _____