

BONE DENSITOMETRY FOLLOW-UP EVALUATION

X-RAY# _____ F/U _____

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

DATE OF BIRTH _____ HOME PHONE NUMBER _____

DATE OF LAST SCAN _____ REFERRING DOCTOR _____

ANY FRACTURED BONES SINCE LAST SCAN YES ___ NO ___

IF YES, PLEASE LIST _____

<u>MEDICATIONS</u>	<u>YES</u>	<u>NO</u>	<u>HOW LONG</u>
<i>CALCIUM SUPPLEMENT</i>	___	___	_____
<i>HORMONES</i>	___	___	_____
<i>EVISTA</i>	___	___	_____
<i>ACTONEL</i>	___	___	_____
<i>BONIVA</i>	___	___	_____
<i>CALCITONIN (MICALCIN)</i>	___	___	_____
<i>FOSAMAX</i>	___	___	_____
<i>FORTEO</i>	___	___	_____
<i>STEROIDS</i>	___	___	_____
<i>THYROID MEDICATION</i>	___	___	_____
<i>ANTICONVULSANTS</i>	___	___	_____

COMMENTS _____

Radiologist's Signature _____

Is there any chance of pregnancy?

YES NO

Signature _____ Date _____