



## Bone Mineral Density Questionnaire

Name: \_\_\_\_\_

Today's Date: \_\_\_/\_\_\_/\_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_\_\_

Sex:  Male  Female

Ethnic Origin:  African-American  White, Caucasian  Hispanic  Asian  Other

Please check the appropriate answer:

	Yes	No
<b>Gynecological History</b>		
1. Have you gone through menopause?	_____	_____
2. Have you had a hysterectomy?	_____	_____
3. Have you had your ovaries removed?	_____	_____
4. Absence of menstruations (i.e. loss of period other than pregnancy or menopause)?	_____	_____
5. Do you take hormone therapy in any form at this time?	_____	_____
If so, what type? (Circle one that applies.) 1. Premarin 2. Estrogen 3. Birth Control		

### Medical History

1. Have you ever had a Bone Density (DXA) scan before?	_____	_____
If so, when? _____ Where? _____		
2. Do you have a family history of Osteoporosis?	_____	_____
3. Have you taken Cortisone or Prednisone orally for over 3 months?	_____	_____
4. Do you take any medication for raising bone density?	_____	_____
<input type="checkbox"/> Fosamax/Alendronate <input type="checkbox"/> Fosamax D <input type="checkbox"/> Boniva <input type="checkbox"/> Actonel <input type="checkbox"/> Evista		
<input type="checkbox"/> Zometa <input type="checkbox"/> Reclast		
If so, how long? _____		
5. Do you take supplemental calcium? <input type="checkbox"/> 1000 mg <input type="checkbox"/> 500 mg <input type="checkbox"/> None		
6. Do you take supplemental vitamin D? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, How much? _____		
7. Have you had hip replacement surgery?	_____	_____
If so, which one? _____		
8. Have you had surgery on your lower back?	_____	_____

### Other Medical conditions: (Check all that apply)

- |  |  |
|--|--|
| <input type="checkbox"/> Personal history of Osteoporosis        | <input type="checkbox"/> Kidney disease          |
| <input type="checkbox"/> Hyperthyroid (overactive thyroid)       | <input type="checkbox"/> Parathyroid disorder    |
| <input type="checkbox"/> Hypothyroid (underactive thyroid)       | <input type="checkbox"/> Rheumatoid arthritis    |
| <input type="checkbox"/> Eating disorder (Anorexia/bulimia)      | <input type="checkbox"/> Asthma                  |
| <input type="checkbox"/> Celiac Disease                          | <input type="checkbox"/> Hypothalamic amenorrhea |
| <input type="checkbox"/> Chronic steroid use, type and duration: |  |

Current Height: \_\_\_\_\_ Previous Height: \_\_\_\_\_ Current Weight: \_\_\_\_\_



### PATIENT SATISFACTION SURVEY

We are striving to provide you with the best possible care. Please help us to achieve this goal by taking a few minutes of your time to answer the following questions. In doing so you will help us to provide optimum care for all our patients.

Date: \_\_\_\_\_

Name: (optional) \_\_\_\_\_ E-mail: \_\_\_\_\_

Type of examination: \_\_\_\_\_

Was it easy to schedule your appointment for today's test?  Yes  No

If no, explain why? \_\_\_\_\_

Was your scheduler: *(Check all that apply.)*

- Courteous?  Yes  No
- Attentive to your needs?  Yes  No
- Efficient?  Yes  No

Was your examination started on time?  Yes  No

If not, how long did you wait for your examination:

- Less than 15 minutes
- 15 – 30 minutes
- 30 minutes or more

If more than 15 minutes, did someone explain the reason for delay?  Yes  No

Was your receptionist: *(Check all that apply.)*

- Courteous?  Yes  No
- Attentive to your needs?  Yes  No
- Efficient?  Yes  No

Was the technologist who performed the procedure: *(Check all that apply.)*

- Courteous?  Yes  No
- Attentive to your needs?  Yes  No
- Efficient?  Yes  No

If your exam required a Radiologist (Doctor): *(Check all that apply.)*

- Courteous?  Yes  No
- Attentive to your needs?  Yes  No
- Efficient?  Yes  No

Please rate your overall experience. *(Circle a number on the scale below to indicate your level of satisfaction)*

1 2  
⏟  
Poor

3 4  
⏟  
Fair

5 6  
⏟  
Satisfied

7 8  
⏟  
Very Satisfied

9 10  
⏟  
Excellent

Any additional comments that you can make would be helpful: *(The use of names would be helpful.)*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Check here if willing to be contacted to provide an online review.

*Thank you for taking the time to complete this survey.*



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## **PREGNANCY CONSENT FORM**

Date: \_\_\_\_\_

This examination requested by my physician is potentially harmful to my pregnancy, and may cause a miscarriage or congenital deformity. I understand this potential risk to the pregnancy and agree to have the examination performed as requested.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_ Date: \_\_\_\_\_