



BONE MINERAL DENSITY PATIENT INFORMATION

Name: _____

Date: _____ Date of Birth: _____

Age: _____ Medical Record Number: _____

Referring Physician: _____ Sex: F M

Ethnicity: This information is required for interpretation only, as Bone Density values may vary in different ethnic group. Please check the appropriate answer:

African-American White/Caucasian Hispanic Asian Other _____

Please check the appropriate answers:

1. Do you have Osteoporosis? Yes No

2. Do you have a family history of Osteoporosis? Yes No

3. Have you had a Hysterectomy (surgical removal of uterus)? Yes No

a. If so, what age? _____

4. Have you gone through menopause? Yes No

a. If yes, indicate age of onset: _____

5. Do you experience post-menopausal bleeding? Yes No

6. Absence of menstruation (i.e loss of period other than pregnancy or menopause)? Yes No

7. Do you take estrogen? Yes No

8. Do you take any other therapy for raising Bone Density? Yes No

a. If yes to 7 or 8 indicate duration _____

9. Have you ever fractured or had surgery to your hip, spine or wrist? Yes No

10. Have you ever been on oral steroids (tablets) for longer than 3 month? Yes No

11. HEIGHT _____ 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.

Name: (optional) _____ Date: _____

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.)*

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: _____