**Radiology Associates of Brooklyn, LLP** **(718) 332-6800**

ALLEN B. ZELMAN, M.D.
HARVEY COOPERSMITH, M.D.
MARTIN I. ELSANT, M.D.
DANIEL B. NOROWITZ, M.D.

## BONE DENSITY STUDY

Today's Date: _____

NAME: _____ DATE OF BIRTH: _____

SEX: _____ AGE: _____

EYE COLOR: _____ ETHNIC GROUP: _____

HEIGHT: _____ WEIGHT: _____

AGE OF MENOPAUSE: _____ AGE OF FIRST MENSTRUATION: _____

NUMBER OF CHILDREN: _____ DRINK ALCOHOL? _____

DO YOU SMOKE? _____ SOCIAL SECURITY # _____

Do you have any family history of height loss, rounding of the shoulders or osteoporosis?

_____

Do you have any of the following medical conditions?

Thyroid problems:____ Asthma:____ Diabetes:____

Rheumatoid arthritis: ____ Epilepsy: ____

Other Medical problems: _____

Do you take any of the following medications?

Estrogen/Progesterone: ____ Birth control pills: ____ Diuretics: ____

Dilantin: ____ Cortisone/Predizone: ____ Antacids: ____

Do you exercise? _____

Have you ever had any fractures? _____

Do you take calcium or Vitamin D? _____

Why are you having this scan? _____

Are you taking any medications for Osteoporosis? _____