



4) In the past 7 days have you had any surgeries or testing done?

Yes or No

5) In the past 2 weeks have you had a barium X-ray done?

Yes or No

6) Do you use tobacco products? Yes or No

If yes, how often? \_\_\_\_\_

7) Have you ever had a bone density test?

Yes or No

If so when? \_\_\_\_\_

8) Do you take any calcium supplements?

Yes or No

If so did you take them today?

Yes or No

9) Do you take any prescribed medications for Osteoporosis or Osteopenia?

Yes or No

If so did you take them today?

Yes or No

10) Would you like a copy of the report mailed/emailed to your home?

(Please note: a blue card (same as for labs) will be sent

Yes or No

or a verbal notification will be given. Report will be in your patient record)

11) Who recommended you get a bone density test and/or who is your

physician (Carol/Bander)? \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Employee (witness) Signature

\_\_\_\_\_  
Date

**By signing above you are giving us permission to do the Bone Density Test. Any and all information given is correct to the best of your knowledge and you understand that your insurance may not cover all or any expenses pertaining to this test.**

17 (3/20/2020)