



**AUSTIN RADIOLOGICAL ASSOCIATION  
PEDIATRIC BONE DENSITOMETRY**

PT. NAME: \_\_\_\_\_  
ACC: \_\_\_\_\_  
MRN: \_\_\_\_\_

**PEDIATRIC BONE DENSITOMETRY**

DATE: \_\_\_\_\_

HISTORY: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

MEDICATIONS: \_\_\_\_\_  
\_\_\_\_\_

HEIGHT: \_\_\_\_\_

WEIGHT: \_\_\_\_\_

AGE: \_\_\_\_\_

TANNER STAGE: \_\_\_\_\_

- Y / N Have you had barium or IV contrast for any X-ray, CT, or Nuclear Medicine exams in the past month? If yes, when \_\_\_\_\_
- Y / N Lumbar spine surgery? Left or right hip surgery? If yes, circle appropriate area.
- Y / N Previous Bone Density exam? When: \_\_\_\_\_  
Where: \_\_\_\_\_