AUSTIN RADIOLOGICAL ASSOCIATION
PEDIATRIC BONE DENSITOMETRY

Name: _____ ACC: _____ MRN: _____

PEDIATRIC BONE DENSITOMETRY

Date: _____

History:

Medications:

Height: _____

Weight: _____

Age: _____

Tanner Stage: _____

Have you had barium or IV contrast for any X-ray, CT, or Nuclear Medicine exams in the past month? ☐ YES ☐ NO

If yes, when _____

Lumbar spine surgery? Left or right hip surgery? If yes, circle appropriate area. ☐ YES ☐ NO
(check appropriate answer)

Previous Bone Density exam? *(most recent only)*

When: _____ Where: _____