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: _____________