**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: _____