Southwest X Ray®
Affordable ADVANCED TECHNOLOGY

Bone Density Questionnaire (CUESTIONARIO DE DENSITOMETRIA)

Name (Nombre): ____

Date of Birth(Fecha de nacimiento): ______________________________________

Referring Physician (Referido(a) por): ______________________________________

Previous Bone Density? (A tenido una densitometria antes?): ____________________________

How tall are you? (Cuanto mide de estatura?): ______ **What is your weight? (Cuanto pesa?)** __________

How much caffeine do you drink? (Cuanta cafeina toma al dia?): ____________________________

Do you smoke? (Usted fuma?): ____________

Do you drink alcohol? (Toma bebidas alcoholicas?): **None (Nada)** ________ **Moderate (Moderado)** _______________ **Heavy (Mucho)**

Have you had any back or hip surgery? (A tenido alguna cirugia de su espalda o cadera?):

____

Any personal history of cancer? (A tenido alguna historia de cancer personal?):

____

Did you have chemotherapy? (Le dieron quimoterapia?): ____

Are you pregnant? (Esta usted embarazada?) _________________

When was your last period? (Cuando fue su ultima menstruacion?): _________ **Menapuse age? (A que edad empezo su menopausia?):** ________________

Did you have a hysterectomy?(Le quitaron la matriz?) ________________ **Were your ovaries removed? (Le quitaron los ovarios?)** ____

Have you ever taken hormones? (A tomado hormonas?) ____

Please list your mediacation. (Cuales son sus medicamientos?)

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