OMB # 0925-0414 Exp: 4/06

- Affix label here -

Clinical Center/ID: __ __ __ __ - ___ ___ ___ - __

First Name _____M.I._____

Last Name _____

1. Date of scan: ☐☐-☐☐-☐☐ (M/D/Y)
2. Performed by: ☐☐☐
3. Contact type:
   - ☐ 1 Phone
   - ☐ 2 Mail
   - ☐ 3 Visit
   - ☐ 8 Other
4. Visit type:
   - ☐ 1 Screening #☐
   - ☐ 2 Semi-Annual #☐☐
   - ☐ 3 Annual #☐☐
   - ☐ 4 Non-Routine

CHECKLIST

5. **"Have you had any fracture or replacement of the following?"**

	No	Yes	→	**"Which Side?"**	
Femur?	____	____		____ Left	____ Right
Hip?	____	____		____ Left	____ Right

(If hip replacement on both sides, do not do bone scan.)

6. **"Do you have any metal objects (such as staples or a pacemaker) in the area of the abdomen?"**

____ No ____ Yes

7. **"Have you had any of the following tests within the past ten days?"**
   - a) **"Barium enema"** ____ No ____ Yes
   - b) **"Upper GI X-ray series"** ____ No ____ Yes
   - c) **"Lower GI X-ray series"** ____ No ____ Yes
   - d) **"Nuclear medicine scan"** ____ No ____ Yes
   - e) **"Other tests using contrast ('dye') or radioactive materials"** ____ No ____ Yes

(If yes to any, you may need to reschedule the bone density measurement; consult with CC physician.)

TESTING

8. Bone Density Measurement completed for:

	No	Yes		Current Bone Scan Number	Comparison Bone Scan Number
8.1. **Hip?**	☐ 0	☐ 1	→	8.1.1. ☐-☐☐☐☐☐☐-☐☐	8.1.2. ☐-☐☐☐☐☐☐-☐☐
				8.1.3. At screening: Baseline Femoral Neck BMD ☐.☐☐	
8.2. **Spine?**	☐ 0	☐ 1	→	8.2.1. ☐-☐☐☐☐☐☐-☐☐	8.2.2. ☐-☐☐☐☐☐☐-☐☐
8.3. **Total Body?**	☐ 0	☐ 1	→	8.3.1. ☐-☐☐☐☐☐☐-☐☐	8.3.2. ☐-☐☐☐☐☐☐-☐☐

K _____ V _____