

**Bone Densitometry
Dexa Scan**

Date of Exam: _____

Medical Record No: _____

Patient Name: _____

Date of Birth: _____

Referring Physician: _____

Race (Please Check One):

- Afro-American Caucasian Native American Oriental Other

1. Have you fractured any bones during your adult life? Yes No

If yes, please list what bones? _____

2. Is there a family history of osteoporosis? Yes No

3. Do you smoke more than 1/2 a pack of cigarettes per day? Yes No

4. Have you smoked in the past? Yes No

5. How many servings of dairy products do you consume per day? _____

(One Serving= 8 oz Milk, 1 oz Cheese, container of yogurt or serving of ice cream) Yes No

6. Have you consumed three or more dairy serving per day (as defined) most of your life? Yes No

7. Do you take a calcium supplement daily? Yes No

If yes, what is the name of the supplement? _____

How much do you take? 0- 500 mg/day 501-1000 mg/day >1000 mg/day

8. Do you exercise at least three times per week? Yes No

What type of exercise do you do? _____

9. Do you drink more than two alcoholic drinks per day? Yes No

10. Have you taken any of the following medication? If yes, please list how long.

a. Steroids (prednisone, cortisone, etc) _____ Yes No

b. Thyroid medication _____ Yes No

c. Anticonvulsants (for seizures, epilepsy) _____ Yes No

11. Please List all Medications you are on, including the dose and length of time taken:

Drug Name	Dose	How often is medication taken? (Daily, Weekly, Monthly)

Please Fill Out Other Side

12. Have you had any of the following conditions?
- | | | |
|-----------------------------------|------------------------------|-----------------------------|
| a. Partial or Complete Paralysis? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Kidney Disease? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Rheumatoid Arthritis? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. Other Arthritis? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. Part of stomach removed? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| f. Intestinal or bowel disease? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
13. Have you had surgery to you back?
- | | | |
|---|------------------------------|-----------------------------|
| a. If yes, what type of surgery? _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. What level was the surgery at? _____ | | |
| c. What year was the surgery? _____ | | |

Remaining Questions for FEMALE Patients Only

14. Have you gone through menopause (change of life)? Yes No
 If yes, did your menopause occur before age 45? Yes No
 What age did you menopause occur? _____
15. Do you have amenorrhea (never started periods or ended at a young age)? Yes No
16. Do you take hormones (Premarin, estrogens, etc)? Yes No
17. Have you any of the following side effects from hormones?
- | | | |
|-------------------------------------|------------------------------|-----------------------------|
| a. Breast soreness? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Heavy periods or other bleeding? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Headaches? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. Weight gain or fluid buildup? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. Other, please list. _____ | | |
18. How long have you taken or did you take hormones? _____
19. Have you had any of the following conditions?
- | | | |
|---|------------------------------|-----------------------------|
| a. Hysterectomy? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Ovaries removed? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Blood clots? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If yes, were you on hormones at the time? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. Breast Cancer? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. Family history of breast cancer? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| f. Cancer of the uterus (womb)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Height _____ Inches

Weight _____ Pounds

Technologist Name: _____

Technologist Signature _____