

Last Name	First Name	MI	DOB	Age	Sex <input type="checkbox"/> F <input type="checkbox"/> M	Self-Referred? <input type="checkbox"/> YES <input type="checkbox"/> NO
Doctor		Doctor Address			Doctor Phone	

PATIENT HISTORY FORM - DEXA

Is there a chance that you are pregnant? NO YES **If you answered "yes" to any of these questions, speak to our receptionist right away.**

Have you had a barium X-Ray in the last 2 weeks? NO YES

Have you had a nuclear medicine scan or injection of an X-Ray dye in the last week? NO YES

Have you ever had a bone density test? NO YES, When and Where? _____

Current Height: _____ Have you noticed a change in height? NO YES Weight: _____

Ethnicity:

- White
- Hispanic/Latino
- African American
- American Indian / Alaska Native
- Asian
- Pacific Islander
- Other _____
- Decline to Answer

Do you take the following Supplements? Calcium, including TUMS Vitamin D None

Have you been treated with any of the following medications?

- Hormone Replacement Therapy (Estrogen)
- Testosterone
- Alendronate (Fosamax)
- Cortisone
- Tamoxifen
- Raloxifene (Evista)
- Prednisone
- Etidronate (Didronel/Didrocal)
- Risedronate (Actonel)
- Intravenous pamidronate (Aredia)
- Clodronate (Bonafos, Ostac)
- Calcitonin (Miacalcin nasal spray)
- PTH (Forteo)
- Zoledronic acid (Zometa)
- Sodium fluoride (Fluotic)

Have you been diagnosed with any of the following medical conditions?

- Medication-induced osteoporosis
- Hypercalcemia
- Congestive heart failure
- Rheumatoid arthritis
- Lupus
- Crohn's disease
- Celiac disease
- Diabetes Mellitus Type I
- End of stage renal disease
- Cushing's syndrome
- Hyperparathyroidism
- Emphysema
- Bone Cancer

Smoking History:

- Current every day smoker
- Current some day smoker
- Former smoker
- Never smoker
- Unknown if ever smoked
- Smoker, current status unknown
- Heavy tobacco user
- Light tobacco user

Alcohol Consumption:

- Zero units a day
- One to Two units a day
- Three or more units a day

Current List of Medications:

Name	Mg	Dose

Have you ever had a broken bone? NO YES If yes, please fill out the chart below:

Bone Broken	Simple fall?	If not a simple fall, please describe the circumstances	At what age?
	<input type="checkbox"/> NO <input type="checkbox"/> YES		
	<input type="checkbox"/> NO <input type="checkbox"/> YES		

Have you ever had surgery of the spine, hips, legs, or arms? NO YES

If yes, please describe type of surgery and which side was affected:

FOR TECHNOLOGIST USE ONLY:

DOS: _____

PROC CODE: _____

TECH: _____

For Women Only: Still In Menses? NO YES Menopause? NO YES, At age _____

Before menopause, have you ever missed you periods for six (6) months (besides pregnancy) NO YES

Hysterectomy? NO YES, At age _____ Removal of Both Ovaries? NO YES, age _____