

DEXA SCREENING FORM

DEXA SCAN

Patient History

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1. Name _____ SS # _____
2. Date of Birth _____ Zip Code _____
3. Weight _____
4. Height _____
5. Race
 African American Asian Caucasian
 Hispanic Native American Other
6. Sex: Female Male
7. Doctors you wish to receive a report _____
- | | YES | NO |
|--|--------------------------|--------------------------|
| 8. Do you have a family history of osteoporosis? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you every broken any bones during your adult life? | <input type="checkbox"/> | <input type="checkbox"/> |
| a. If you had a fracture of bones, at what age? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| b. How did you break the bone? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you smoke or have a history of smoking? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do you have three or more servings of dairy products every day? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you drink more than 2 alcoholic beverages a day? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you drink more than 2 caffeinated beverages a day? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Do you take a calcium supplement daily? | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, how much? | | |
| 0-500 mg/day <input type="checkbox"/> 501-1000 mg/day <input type="checkbox"/> >1000 mg/day <input type="checkbox"/> | | |
| 15. Do you exercise regularly? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Have you ever had chemotherapy? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Have you taken any of the following medications or treatments? | <input type="checkbox"/> | <input type="checkbox"/> |
| a. Steroids (Prednisone, Cortisone, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Thyroid medication | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Anticonvulsants (for seizures, epilepsy) | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Loop diuretics (Lasix, Bumex, Edicrin) | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Heparin | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Lithium | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Have you had any of the following conditions? | <input type="checkbox"/> | <input type="checkbox"/> |
| a. Hyperthyroidism or hyperparathyroidism | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Biliary cirrhosis | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Kidney disease | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Rheumatoid arthritis | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Other arthritis | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Part of stomach removed | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Intestinal or bowel disease | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Eating disorders (anorexia nervosa, bulimia, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| i. History of COPD | <input type="checkbox"/> | <input type="checkbox"/> |
| j. History of Back Pain | <input type="checkbox"/> | <input type="checkbox"/> |
| k. History of Height Loss | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Do you have any general comments about your health? | | |
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DEXA SCREENING FORM

FEMALE PATIENTS:

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Have you gone through menopause? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Did your menopause occur before age 45?
Age _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had amenorrhea
(missed periods or never started period)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever taken hormones (not including birth control pills)?
If so, for how many years? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever had any of the following side effects from hormones? | <input type="checkbox"/> | <input type="checkbox"/> |
| a. Breast tenderness | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Heavy periods or intermittent bleeding/spotting | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Headaches | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Weight gain or fluid build-up | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Other | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever been treated for osteoporosis or weak bones?
If so, what was the treatment? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you had any of the following conditions? | <input type="checkbox"/> | <input type="checkbox"/> |
| a. Hysterectomy (womb removed) | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Ovaries removed | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Blood clots | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Breast cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Family history of breast cancer. | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Cancer of the uterus (womb) | <input type="checkbox"/> | <input type="checkbox"/> |

What influenced you to choose our facility for your Radiology needs?

Doctor referral Advertising Friend or Family Other _____

For office use only

Height _____ Inches Weight _____ pounds MRN _____