# The ImageCare Centers Rockaway

## DEXA Scan History

Date ____/____/_____

**To be filled out by patient**

Name:_____ DOB:____/____/_____

Referring Physician:_____

Race: African –American_____ Caucasian:_____ Asian:_____ Hispanic:_____ Other:_____

Male:____ Female____

Do you take prescription medication to treat or prevent osteoporosis? Y N

If so, what is it? _____

Height:_____ Weight_____

Are you on, or have you been on steroid treatments? Y N
Are you a current smoker? Y N
If you were a smoker, when did you stop?_____ years ago
Do you drink more than three alcoholic drinks per day? Y N
Do you have a family history of hip fractures? Y N
Do you have a family history of osteoporosis? Y N
Do you take medication for the treatment of your thyroid? Y N
Do you have rheumatoid arthritis? Y N
Do you have any metal implants in your:
Spine? Y N
Left Hip? Y N
Right Hip? Y N
Have you had a contrast study within the past 3 days? Y N
Have you fractured any bones, **without trauma**, since your 18th birthday? Y N
If yes, which bone/s?_____
Have you taken any Tums or multivitamins with calcium, or a calcium supplement today? Y N

**Women only**

Have you had a partial hysterectomy? Y N Total hysterectomy? Y N
If yes, at what age?_____
Have you been through menopause? Y N If yes, age of onset?_____
Do you take hormones (Premarin, Estrogen, Etc.)? Y N
Have you taken hormones in the past? Y N