

The ImageCare Centers Vernon

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