assuredimaging

MRN _____

Last Name	First Name	MI	DOB	Age	Sex ☐ F ☐ M	Self-Referred? ☐ YES ☐ NO
Doctor	**Doctor Address**					**Doctor Phone**

PATIENT HISTORY FORM - DEXA

Is there a chance that you are pregnant? ☐ NO ☐ YES

Have you had a barium X-Ray is 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 had hyperparathyroidism or a high calcium level in your blood? ☐ NO ☐ YES

If you answered "yes" to any of these questions, speak to our receptionist right away.

Patient History: Age:_____ Height:_____ Weight:_____ Sex: Male ☐ Female ☐

Ethnicity ☐ Caucasian (White) ☐ Black ☐ Asian ☐ Native American ☐ Hispanic Other _____

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

Are you currently receiving or have you previously received prednisone pills (cortisone)?

YES, currently ☐ YES, previously ☐ NO ☐

Do you take any calcium supplements (including TUMS)? ☐NO ☐YES

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

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?
	☐NO ☐YES		
	☐NO ☐YES		
	☐NO ☐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 Women Only:

Still In Menses? ☐NO ☐YES

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

Menopause? ☐NO ☐YES, At age _____

Hysterectomy? ☐NO ☐YES, At age_____

Removal of Both Ovaries? ☐NO ☐YES, At age_____