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

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

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

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

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 (Bonefos, 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

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?
	☐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 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_____

FOR TECHNOLOGIST USE ONLY:

DOS: _____

PROC CODE: _____

*TECH:*_____