



an MTT Corporation facility

DEXA SCAN PATIENT HISTORY

NAME: _____ DATE: _____

DATE OF BIRTH: _____ MALE _____ FEMALE _____ PHYSICIAN _____

HEIGHT: _____ WEIGHT: _____ HAVE YOU EVER HAD A DEXA SCAN BEFORE? Y N (CIRCLE)

IF THE ANSWER IS YES: WHEN? _____ WHERE? _____

RACE: CAUCASIAN _____ AFRICAN-AMERICAN _____ HISPANIC _____ ASIAN _____ OTHER _____

IS THERE A FAMILY HISTORY OF OSTEOPOROSIS? _____

HAVE YOU EVER HAD A COMPRESSION FRACTURE OF THE SPINE? _____

HAVE YOU EVER HAD ANY SURGERY OR FRACTURES IN THE FOLLOWING AREAS:

- 1. SPINE: _____ WHEN? _____
- 2. HIPS: _____ WHEN? _____
- 3. WRIST: _____ WHEN? _____
- 4. FOREARM: _____ WHEN? _____

DO YOU SMOKE? _____ IF SO, HOW MUCH? _____

DO YOU CONSUME ALCOHOLIC BEVERAGES? _____ IF SO, HOW MUCH? _____

DO YOU TAKE CALCIUM SUPPLEMENTS DAILY? _____ IF SO, HOW MUCH? _____

HOW MANY SERVINGS OF DAIRY PRODUCTS DO YOU CONSUME DAILY? _____

HAVE YOU EVER TAKEN ANY OF THE FOLLOWING MEDICATIONS ROUTINELY AND IF SO, FOR HOW LONG:

- 1. STEROIDS (PREDNISONE, CORTISONE, ETC) _____
- 2. THYROID MEDICATIONS _____
- 3. ANTICONVULSANTS (FOR SEIZURES) _____

HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING CONDITIONS?

- 1. OSTEOPOROSIS: _____ IF YES, WHAT MEDICATIONS? _____
- 2. HYPERPARATHYROIDISM: _____
- 3. KIDNEY DISEASE: _____
- 4. HYPERTHYROID: _____
- 5. AMENORRHEA: _____
- 6. PARKINSON'S DISEASE: _____
- 7. PARTIAL/COMPLETE PARALYSIS: _____
- 8. PART OF STOMACH REMOVED: _____
- 9. INTESTINAL/BOWEL DISEASE: _____
- 10. ANY TYPE OF ARTHRITIS: _____

FOR FEMALE PATIENTS ONLY

HAVE YOU GONE THROUGH MENOPAUSE? _____ IF SO, WHAT AGE? _____

HAVE YOU HAD A HYSTERECTOMY? _____ COMPLETE OR PARTIAL? _____

ARE YOU CURRENTLY TAKING HORMONES? YES OR NO IF NO, HAVE YOU EVER TAKEN HORMONES AND WHEN? _____

****IF YOU ARE A FEMALE BETWEEN THE AGES OF 12-55, PLEASE FILL OUT THE BACK OF THIS FORM****

PREGNANCY INFORMATION

If not applicable, please circle: (N/A)

Recognizing that there is a very small, but unknown risk to a developing fetus exposed to diagnostic levels of radiation, it is imperative that every effort is made to avoid unnecessary exposure to the fetus. For this reason, we require all females ages 12 to 55 to answer the following questions, before proceeding with your x-ray examination.

Patient's Name: _____

Females 12-55 years of age, please answer the following questions:

I understand that radiation can be harmful to the unborn child.

Date of last menstrual period: _____.

Please complete the following:

- I am pregnant.
- I may be pregnant.
- I am not pregnant.

Patient Signature

Date

Parent or Guardian, if under 18

Date