DEXA Bone Densitometry Lab
Patient History

Patient's name:

Age: Sex: Height:

Referring Physician:

Menopause:
Age at onset: Natural or surgical?

Any significant active dental problems?

Taking Estrogen or considering
Estrogen Therapy?

If premenopausal, are periods regular?
Are you pregnant or is there a chance you may be pregnant?

<u>List Medications</u>:

Supplemental Calcium
(yes or no, amount & how long)

Past history of Dilantin/Cortisone/Heparin?

Any medication allergies?

Any lactose or milk allergies?

Any intestinal disorder or abdominal
Surgery? (if so, describe.)

Any problems with your esophagus
(swallowing tube) such as reflux ulcer
or achalasia?

Any family history of Osteoporosis?
(yes or no, and relationship)

Are you willing to take anti Osteoporosis
Treatment if necessary?

Any fractures and locations?
At what age?
Cause of injury?

Exercise habits:

Has your posture changed?

Smoking (yes or no, and amount)
If you quit, when?

Alcohol (yes or no, and amount)?

<u>Any history of</u>:
(If yes, please elaborate)

Weight Loss…………………...yes no
Heart Disease………………yes no
Phlebitis…………………….yes no
Thyroid Disease…………….yes no
Parathyroid Disease………...yes no
Blood Clots…………………yes no
Kidney Disease……………..yes no
Kidney Stones………………yes no
Back Pain…………………...yes no
Anorexia Nervosa…………..yes no
Colitis/Crohn's Disease……..yes no

Any cancer or tumors?
(If so, what type?)

Any family history of breast cancer?
(yes or no, and relationship)

Reason for Bone Density Testing?

Date of last DEXA scan: ____________

Physician Signature: _______________________

Date: _________________________