S A R A

SOUTHERN ARIZONA RADIOLOGY ASSOCIATES

DEXA SCREENING

Patient Name: _____ **DOB:** _____/_____/_____ **Gender:**_____

Referring Physician: _____ **Date of Exam:** _____/_____/_____

Weight: _____**lbs Height:** _____**feet** _____**inches Ethnicity:**_____

Previous Bone Density Test Performed? ☐ YES ☐ NO **When:**_____ **Where:**_____

RELEVANT HISTORY: Do you or have you had any of the following? (indicate YES or NO)

1.) Have you had a previous hip or vertebral/spine fracture ☐ **YES** ☐ **NO**

2.) Have you ever had vertebral/spinal or hip surgery ☐ **YES** ☐ **NO**

3.) Have you had any fractures during your adult life not from an a significant trauma ☐ **YES** ☐ **NO**

4.) Did either of your parents ever have a hip fracture ☐ **YES** ☐ **NO**

5.) Do you have rheumatoid arthritis ☐ **YES** ☐ **NO**

6.) Do you drink 3 or more alcoholic drinks per day ☐ **YES** ☐ **NO**

7.) Do you smoke ☐ **YES** ☐ **NO**

8.) How tall were you at age 25 _____

9.) Do you have any of the following medical conditions?

☐ Osteopenia ☐ Osteoporosis ☐ Anorexia/Bulimia
☐ Asthma/Emphysema ☐ Hyperparathyroidism ☐ End Stage Renal Disease
☐ Any seizure disorder ☐ Inflammatory bowel disease ☐ Cancer, type_____

10.) Have you ever taken any of the following medications?

☐ Actonel ☐ Boniva ☐ Evista ☐ Forteo ☐ Fosamax
☐ Protelos ☐ Reclast ☐ Prolia ☐ Vitamin D ☐ Calcium
☐ Miacalcin ☐ HRT (hormone therapy) ☐ Steroids (longer than 3 months)
☐ Thyroid Medication, type _____

IF FEMALE:

11.) At what age did you period start? _____

12.) Have you been diagnosed with amenorrhea? ☐ **YES** ☐ **NO**

13.) Are you perimenopausal? ☐ **YES** ☐ **NO**

14.) Have you gone through menopause? ☐ **YES** ☐ **NO** If yes, what age?_____

15.) Are you currently taking any hormone replacements? ☐ **YES** ☐ **NO**

16.) Have you had your ovaries removed? ☐ **YES** ☐ **NO** If yes, what age?_____

_____ **Date:** _____/_____/_____

Patient signature (or legal guardian)