Patient History for DEXA Scan

1. Name: _____ DOB: _____ ☐F ☐M
2. Race: ☐ African American ☐ Caucasian ☐ Native American ☐ Asian ☐ Other: _____
3. Have you ever fractured any bones in your adult life? ☐ YES ☐ NO
   If yes, was it your spine? ☐ YES ☐ NO
4. Have you ever been diagnosed with osteopenia? ☐ YES ☐ NO
5. Have you ever been diagnosed with osteoporosis? ☐ YES ☐ NO
6. Have you ever taken any Bone density medicines? ☐ YES ☐ NO
   If yes, please list any current _____
7. Do you smoke or have you smoked in the past? ☐ YES ☐ NO
8. Do you take a calcium supplement? ☐ YES ☐ NO
9. Do you take a multivitamin and/or vitamin D? ☐ YES ☐ NO
10. Have you had any prior bone density/dexa tests before? ☐ YES ☐ NO
    If so, where_____ and when_____
11. Do you have Hyperparathyroidism? ☐ YES ☐ NO
12. Do you have Hypercalcemia? ☐ YES ☐ NO
13. Have you ever taken any medication for the following:
    a. Steroids (prednisone, cortisone, etc.) ☐ YES ☐ NO
    b. Thyroid medication ☐ YES ☐ NO
    c. Anticonvulsants (for seizures, epilepsy) ☐ YES ☐ NO
    If yes, please list any current medications _____
14. Have you ever had the following conditions?
    a. Kidney Disease ☐ YES ☐ NO
    b. Rheumatoid Arthritis ☐ YES ☐ NO
    c. Psoriatic Arthritis ☐ YES ☐ NO

REMAINING QUESTIONS FOR FEMALE PATIENTS ONLY

15. Is there any possibility of pregnancy? ☐ YES ☐ NO
16. Are you experiencing hot flashes, mood swings, sleep disturbances, or night sweats? ☐ YES ☐ NO
17. Have you had your ovaries surgically removed? ☐ YES ☐ NO
18. Have you had a hysterectomy? ☐ YES ☐ NO
19. Have you gone through menopause? ☐ YES ☐ NO
    If yes, at what age? _____
20. Have you ever taken hormone replacement therapy? ☐ YES ☐ NO
    List any you currently receive _____
21. Have you ever had breast cancer? ☐ YES ☐ NO

I am absolutely certain I am not pregnant ☐ YES ☐ NO
LMP: _____

FOR OFFICE USE ONLY:
Height: Weight:

_____ _____ _____
Patient Signature Date Time

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

☐ Interpreter Accepted _____ ☐ Interpreter Refused
(Name/Number of Person/Services Chosen/Used)

NOVANT HEALTH
Patient History for DEXA Scan

Name / MR # / Label