Please bring this to your DEXA Bone Density Appointment

APPT SCHEDULED_____

Name_____ **Date of Birth**_____

Physician: BEAL COX DONNELLY GEHRING GRAY HUBBARD RIBAUDO WILLIAMSON ZANOVICH

Race: Caucasian African American Hispanic Asian Other_____

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WE WILL CALL WITH YOUR RESULTS/MAY WE LEAVE RESULTS ON YOUR VOICEMAIL?_____

1st #_____ **2nd #** _____

ANSWER THE QUESTIONS BELOW. IF YOUR ANSWER IS "YES," PLEASE ENTER ADDITIONAL INFORMATION IN QUESTION BOX.

GYNECOLOGICAL HISTORY	YES	NO
Are (were) your periods regular between ages 18 and 40?		
Did you have intervals with few or no bleeding cycles, other than pregnancy? Age___		
Have you had a hysterectomy? If yes, what year _____		
Do you have both ovaries?		
Have you entered menopause? If yes, what year_____		
MEDICATIONS		
Are you now taking hormone replacement medication?		
Do you take cortisone, prednisone, or other steroids for treatment of asthma, arthritis, or cancer?		
Do you take prescription sleeping aids? If yes, how often _____		
Do you take thyroid medication?		
Do you take a calcium + vitamin D supplement? If yes, mg daily_____		
Do you consume dietary calcium regularly? i.e., milk/cheese/yogurt		
LIFESTYLE		
Do you smoke cigarettes? Packs per day_____		
Do you drink alcoholic beverages? Drinks per day_____		
Do you drink caffeinated beverages? Drinks per day_____		
Do you exercise regularly? How often?		
FRACTURES (BROKEN BONES)		
Have you ever broken any bones? If yes, what year_____		
Which bone was broken_____ How?_____		
Have you had a hip replacement? If yes, what year_____ Right hip__ Left hip__ Both hips__		
Did your mother or father ever have a broken hip?		
HISTORY OF OSTEOPOROSIS		
Have you been diagnosed with Osteoporosis or Osteopenia?		
Family history of osteoporosis? Who?_____		
BONE DENSITY SCAN		
Have you had a previous dexa scan? When?_____ Where_____		
Do you have any metal hardware surgically implanted? Where_____		

LIST CURRENT PRESCRIPTION MEDICATIONS
LIST OVER-THE-COUNTER MEDICATIONS (multi-vitamin, calcium, vit D, etc.)

Patient Signature_____ **Date**_____ Revised 05/2010

IF YOU ARE PREGNANT OR THINK YOU MAY BE PREGNANT, TELL THE NURSE BEFORE YOUR BONE DENSITY SCAN.
THIS PROCEDURE INVOLVES EXPOSURE TO RADIATION – CHILDREN AND OTHER ADULTS SHOULD REMAIN IN THE WAITING ROOM AREA.