WASHINGTON RADIOLOGY

DXA Patient History

For Office Use Only
Place Patient ID label here

Patient name _____ Exam date _____ ◯ Female ◯ Male

Age _____ Weight _____ lbs Height _____ ft _____ in Ethnicity _____

Reason for exam _____

FOR OFFICE USE ONLY Measured wt _____ lbs Measured ht _____ ft _____ in Technologist _____

PLEASE COMPLETE THE FOLLOWING QUESTIONNAIRE. If you answer YES to either of these first two questions, do not continue with this questionnaire. Return all forms to the receptionist, and a technologist will speak to you shortly.

◯ Y ◯ N Are you or do you suspect that you are pregnant?
◯ Y ◯ N Have you had any exam using ingested barium within the past 7 days?

HISTORY

◯ Y ◯ N Have you had a DXA (Bone Density) scan in the past? When? _____ Where? _____
◯ Y ◯ N Prior surgery to your hip(s) or spine? If yes, please explain. _____
◯ Y ◯ N Do you have Hyperparathyroidism?
◯ Y ◯ N *Female patients only:* Have you gone through menopause? If yes, at what age? _____

RISK FACTORS FOR OSTEOPOROSIS

◯ Y ◯ N Loss of height. If yes, your height as a young adult: _____
◯ Y ◯ N Family history of osteoporosis/osteopenia
◯ Y ◯ N Has either biological parent had a broken hip?
◯ Y ◯ N Have you fractured a bone/had a stress fracture since age 40 other than hands, feet, skull? Age? ____ Body part? _____
◯ Y ◯ N Do you currently smoke cigarettes?
◯ Y ◯ N Do you have more than 2 drinks of alcohol per day?
◯ Y ◯ N Have you taken daily steriods (e.g. prednisone) for 3 or more months?
◯ Y ◯ N Do you have a condition known to be associated with bone loss (e.g. diabetes, absorption disorder, premature menopause, crohn's disease)?
◯ Y ◯ N Have you been diagnosed with rheumatoid arthritis? (not osteoarthritis)
◯ Y ◯ N Vitamin D deficiency
◯ Y ◯ N Stomach bypass or banding surgery

CURRENT MEDICATIONS

◯ Y ◯ N Calcium and/or Vitamin D supplements
◯ Y ◯ N HRT (Hormone Replacement Therapy)
◯ Y ◯ N Anticonvulsants (Seizure medications). If yes, name of medication: _____
◯ Y ◯ N Thyroid medications. If yes, name of medication: _____
◯ Y ◯ N DepoProvera
◯ Y ◯ N Are you currently taking prescription medication for osteopenia or osteoporosis. If yes, how long? _____
Check all medications that apply:
◯ Fosamax ◯ Actonel ◯ Miacalcin ◯ Boniva ◯ Evista ◯ Reclast ◯ Other _____
◯ Y ◯ N Have you taken prescription medication in the past for osteopenia or osteoporosis?
If yes, how long? _____ List medication: _____

Patient signature _____ Date _____ Technologist _____