DEPARTMENT OF DIAGNOSTIC IMAGING
BONE DENSITOMETRY (DEXA) STUDIES

Name: _____

SS: _____

Zip Code: _____

Race:
- ☐ Caucasian
- ☐ African-American
- ☐ Oriental
- ☐ Hispanic
- ☐ Other

Family Physician _____

Referring Physician: _____

Date of Birth: _____

Today's Date: _____

Age: _____

Present Actual Height: _____

Actual Weight: _____

Have you fractured any bones during your adult (16 years or older) life? ☐Yes ☐No If yes what was broken? _____

Is there a family history of osteoporosis? ☐Yes ☐No

Do you take any of the following regularly?

☐ Calcium supplement _____mgs./day ☐ Multi-Vitamin ☐ Vitamin D supplement ☐ None

Please list medications you currently take: _____

Please list any medications you have taken for more than one month: _____

_____

Have you had any of the following conditions?

Hyperparathyroidism	☐Yes ☐No	Turner's Syndrome	☐Yes ☐No
Malabsorption	☐Yes ☐No	Diabetes	☐Yes ☐No
Rheumatoid Arthritis	☐Yes ☐No	Kidney Disease	☐Yes ☐No
Part of stomach Removed	☐Yes ☐No	Arthritis of Spine	☐Yes ☐No
Long term Antacid use	☐Yes ☐No	Part of Intestine removed	☐Yes ☐No
Excessive Dental cavities	☐Yes ☐No	Periodontal (gum) disease	☐Yes ☐No
Inflamatory Bowel disease	☐Yes ☐No		

******The remaining questions are for women only******

Hysterectomy ☐Yes ☐No If yes, date: _____

Ovaries removed ☐Yes ☐No If yes, date: _____

Post Menopausal ☐Yes ☐No If yes, date: _____

Are you/have you taken estrogen replacements? ☐Yes ☐No If discontinued, age and reason _____

Have you/are you taking birth control pills? ☐Yes ☐No Age Discontinued _____

DO NOT WRITE BELOW THIS LINE

EXAM DENSITY RESULTS **TODAYS DATE:** _____

	PT'S ACTUAL BMD (gm/cm2)	PT'S T-SCORE	S.D.	COMPARE
HIP (AP)				
WARDS TRIANGLE				
SPINE (AP)				
SPINE (LAT)				
RADIUS (DISTAL)				