



Elizabeth Wende Breast Care, LLC

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DEXA BONE DENSITOMETRY - PATIENT HISTORY FORM

Please have both sides of this form filled out before coming for your appointment.

Account #

Have you ever had a DEXA Scan before?
 Yes No

If Yes, where was the scan done?

Date of last DEXA Scan: _____

How did you hear about us? _____

Your DEXA appointment is scheduled for:

Date:

Time:

Referred for DEXA by:

Dr. _____

Address: _____

Street

City State Zip

Reason for today's DEXA scan:

List names and addresses of other doctors you would like a report sent to:

Dr. _____

Address: _____

Street

City State Zip

Dr. _____

Address: _____

Street

City State Zip

Dr. _____

Address: _____

Street

City State Zip

Personal Information

Home Phone: (____) ____ - _____

Date of Birth: _____

Age: ____ Height: ____ Weight ____

Social Security Number:
____ - ____ - ____

Your Employer: _____

Business Phone: (____) ____ - _____

**PLEASE BRING YOUR
INSURANCE CARDS**

Please Note: There will be an additional \$20 charge for co-payments not received at time of service.

Please complete both sides of form before arriving for your appointment.

Medical Information

Name: _____

Sex: Male Female Age: _____

Race: African American Caucasian Hispanic Asian Other

WOMEN ONLY

Have you been through menopause?..... Yes No

If yes, at what age did it occur? _____

Do you have amenorrhea (never started periods, or periods ended at a young age)?..... Yes No

Do you now take hormones (Premarin, estrogens, etc.)?..... Yes No

If yes, how long have you taken hormones? _____ years.

If you have ever taken hormones (NOT including birth control pills), please state when and for how long.

Have you had any of the following? Hysterectomy Ovaries removed
 Breast cancer Cancer of the uterus
 Blood clots

If so, were you on hormones at the time?..... Yes No

ALL PATIENTS

Have you ever taken, or are you now taking any of the following medications?

Steroids (prednisone, cortisone, etc.) Thyroid medication Actonel Calcitonin
 Anticonvulsants (for seizures, epilepsy) Fosamax Evista Boniva
 Aromatase inhibitors(Aromasin, Arimidex) Depo-provera Forteo Zometa Tamoxifen

If yes, when did you take it and for how long? _____

Do you have a family history of breast cancer?..... Yes No

If yes, what relationship, and diagnosed at what age ?

Self - age _____ Mother - age _____ Sister - age _____

Daughter - age _____ Grandmother - age _____ Other _____ age _____

Did your doctor order this test for you?..... Yes No

Have you ever had surgery on your spine or hip?..... Yes No

If yes, explain _____

Have you ever fractured your spine or hip?..... Yes No

If yes, where was the fracture? _____ When did it happen? _____

Have you fractured any bones during your adult life?..... Yes No

If yes, what bone did you fracture? _____ When did it happen? _____

Do you have a family history of osteoporosis?..... Yes No

If yes, who in your family has osteoporosis? _____

Do you smoke?..... Yes No

Have you smoked in the past?..... Yes No

Do you take a calcium supplement daily?..... Yes No

If yes, how much? 0 - 500mg/day 501 - 1000mg/day more than 1000mg/day

Do you exercise at least three times per week?..... Yes No

Do you drink more than two alcoholic drinks per day?..... Yes No

Have you had any of the following conditions?

Rheumatoid arthritis Partial or complete paralysis or immobilization due to injury
 Other type of arthritis Hyperthyroidism (over-active thyroid)
 Part of stomach removed Hypothyroidism (under-active thyroid)
 Intestinal or bowel disease Hyperparathyroidism
 Organ transplant recipient Kidney disease
 Heart disease

MEN ONLY -

Hypogonadism /
Low testosterone level

Have you had any contrast-media x-ray exams in the last 2 weeks? (ie. barium enema or upper GI) Yes No

Do you have any general comments about your health? _____

PLEASE LIST ALL CURRENT PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS:

EWBC-05 SEPT08

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