PLEASE DO NOT TAKE VITAMINS, CALCIUM SUPPLEMENTS, TUMS OR ROLAIDS on the day of your appointment or we will have to reschedule your bone density appointment. Please continue to take all prescription medications.

ABOUT THIS VISIT
1. Reason for this Dexa scan: ________________________________________________________________
2. Have you ever had a DEXA scan? ❑ No ❑ Yes
   If yes, ❑ EWBC, when ______________________ OR ❑ Other facility, when ______________________

SOCIAL HISTORY
3. Gender: ❑ Male ❑ Female
4. Do you drink alcohol? ❑ No ❑ Yes: How often________________________
5. Smoking status: ❑ Current, every day ❑ Current, some day smoker ❑ Former smoker
   ❑ Never smoker ❑ Denied ❑ Smoker, current status unknown ❑ Unknown if ever smoked
   ❑ Heavy tobacco smoker ❑ Light tobacco smoker
6. Race: ❑ White ❑ African American ❑ American Indian or Alaska Native ❑ Asian
   ❑ Native Hawaiian or Pacific Islander ❑ Other, Race:_________
7. Ethnicity: ❑ Not Hispanic/Latino ❑ Hispanic/Latino
8. Preferred Language: ❑ English ❑ Other________________________
9. Height ___ft ___in Weight _______

QUESTIONS FOR FEMALE PATIENTS
10. Are you post menopausal? ❑ No ❑ Yes, age entered menopause _______
11. Hormone replacement: Usage: ❑ never ❑ unknown ❑ over 5 yrs ago ❑ less than 5 yrs ago ❑ current
    Length of time on HRT: ___ months ___years
12. Please check off if you have you had any of the following:
    ❑ Hysterectomy ❑ Ovaries removed ❑ Breast cancer ❑ Cancer of the uterus ❑ Blood clots
    If you “checked” any of the above questions, were you taking hormones at the time? ❑ Yes ❑ No

QUESTIONS FOR MALE PATIENTS
13. Do you have Hypogonadism/Low testosterone level: ❑ No ❑ Yes

QUESTIONS FOR ALL PATIENTS
14. PERSONAL HISTORY (please check if applies to you)
   Are you currently taking any of the following medications?
   ❑ Steroids (prednisone, cortisone, etc.) How long:____
   Have you taken 5mg/day or equivalent for 3 or more months? ❑ Yes ❑ No
   ❑ Aromatase inhibitors (Aromasin, Arimidex) ❑ Thyroid medication ❑ Actonel
   ❑ Calcitonin ❑ Prolia ❑ Anticonvulsants (for seizures, epilepsy)
   ❑ Evista ❑ Boniva ❑ Tamoxifen
   ❑ Depo-provera ❑ Fosamax ❑ Forteo
   ❑ Zometa ❑ Atelvia ❑ Reclast

-OVER-
15. Please “check off: if any of the following pertains to YOU:

❑ Surgery on your spine or hip: Please explain ______________________ When ________

❑ Fractured your spine or hip: where was fracture ______________________ When did it happen ______

❑ Fractured any bones after age 40 (excluding skull, hands and feet) ______
  When did it happen? ______

❑ Family history of osteoporosis, who: _______________________________

❑ Either of your parents had a hip fracture

❑ Take a calcium supplement daily:
  Dosage per day  □ 0 to 500mg/day  □ 501-1000mg/day  □ More than 1000 mg/day

❑ Exercise at least three times per week

❑ Had any contrast-media x-ray exams in the last 2 weeks (ie. barium enema or upper GI)

16. Have YOU had any of the following conditions:

❑ Rheumatoid arthritis (diagnosed by a physician)

❑ Other type of arthritis

❑ Organ transplant recipient

❑ Hypothyroidism (under-active thyroid)

❑ Hyperparathyroidism

❑ Partial or complete paralysis or immobilization due to injury

❑ Part of stomach removed

❑ Intestinal or bowel disease

❑ Hyperthyroidism (over-active thyroid)

❑ Heart disease

17. Please list all current prescription and non-prescription medications:

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Print Name:_________________________________________  Sign Name:_________________________________________

Today’s date _____ / _____ / _____  Date of Birth: _____ / _____ / _____  E-Mail :_______________________________