DEXA SCAN INFORMATION SHEET

Patient Name:			Date of Birth:	Age:
Weight:	Height:	Gender:	Ethnicity:	
Next Appt with Physician about these results:				

GENERAL INFORMATION:	
Current Medications:	
Allergies:	
Are you postmenopausal:	❑ Yes ❑ No
Are you on any hormone replacement:	❑ Yes ❑ No
Smoking history:	❑ Current ❑ Past _____ Packs per day x _____ years.
Do you take any steroids on a daily basis:	❑ Yes ❑ No
Do you have a family history of osteoporosis:	❑ Yes ❑ No
Do you take calcium with vitamin D:	❑ Yes ❑ No
Personal history of cancer:	❑ Yes ❑ No If yes, what type:
Personal history of fracture:	❑ Yes ❑ No
Any previous surgery on hips or back:	❑ Yes ❑ No If yes, any metal in back or hip: ❑ Yes ❑ No
Have you had a recent fall or injury that has injured your back or hips?	❑ Yes ❑ No
Any prior DEXA scans:	❑ Yes ❑ No If yes, when and what facility:

Patient Signature: _____