HAZLETON IMAGING

Date of Birth: ____________________________
Referring Physician: _______________________

Age: ______  Sex: ______  Ethnicity: ______
Height: ______  Weight: ______
Appointment Date: 10/24/2008  12:00:00 AM

DEXA SCREENING

Why are you having this examination? ____________________________________________________________

Have you had a Nuclear or Barium study in the last 7 days? Yes ___ No ___

Have you ever had a previous DEXA? Yes ___ No ___  If yes, Where and When? __________________________

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

Current or prior tobacco intake? Yes ___ No ___  If yes, how long, how much? ________________________

Do you drink alcohol? Yes ___ No ___  If yes, amount, and frequency? ________________________________

Do you exercise? Yes ___ No ___

Weight bearing? Yes ___ No ___  If yes, type, duration, and frequency? ______________________________

Is your diet low in dairy products and other sources of calcium? Yes ___ No ___

Are you postmenopausal? Yes ___ No ___  If yes, what age did you start menopause? ____________________

Have you had a hysterectomy? Yes ___ No ___  If yes, when? ____________________ Total or Simple? __________

Did you ever fracture your hip? Yes ___ No ___

Did you ever fracture your wrist? Yes ___ No ___

Have you had other fractures since age 50? Yes ___ No ___

Have you had surgery on your spine? Yes ___ No ___

Have you lost any height? Yes ___ No ___  If yes, how much? _______________________________________

Do you have any of the following: Diabetes, Asthma, Epilepsy, Thyroid disease, parathyroid disease? (Circle)

Have you ever undergone chemotherapy or radiation treatments? Yes ___ No ___

Have you taken calcium or osteoporosis meds in last 48 hours? Yes ___ No ___

Current or prior estrogen or progesterone meds? Yes ___ No ___
   If yes, name, dose, and how long? ____________________________________________________________

Do you take thyroid medications regularly? Yes ___ No ___
   If yes, name, dose, and how long? __________________________________________________________

Do you take prednisone or other steroids regularly? Yes ___ No ___
   If yes, name, dose, and how long? __________________________________________________________

What is your dominant hand? Right ___  Left ___

Do you take vitamins? Yes ___ No ___

Vitamin D? Yes ___ No ___  If yes, dose, and frequency? ____________________________________________

Calcium supplements? Yes ___ No ___  If yes, dose, and frequency? ______________________________

Please list any other medications

(particularly Fosamax, Actonel, Evista, Calcitonin, or Forteo, Anticoagulants, Antiseizure medications)