DEXA (Bone Densitometry Exam)

FIRST NAME: _____ LAST NAME: _____

DOB: ___/___/____ HEIGHT(IN): _____ WEIGHT(LBS): _____

GENDER: FEMALE ___ MALE ___

HISTORY OF NONTRAUMATIC FRACTURES:

FEMUR: YES____ NO____ FOREARM: YES____ NO____
HUMERUS: YES____ NO____ PELVIS: YES____ NO_____
SPINE: YES_____ NO_____ Hip: YES____ NO____

INDICATIONS: (mark the ones that apply)

HYPERTHYROID___ CORTICOSTEROID___
LOW BODY WEIGHT___ FAMILY HISTORY OF FRACTURE___
HEIGHT LOSS___ CAUCASIAN___
TOBACCO USER___ EARLY MENOPAUSE___
HYPOTHYROID___ AMENORRHEA___
ALCOHOLISM___ OSTEOPOROTIC___
RENAL DISEASE___ BILATERAL OVARIAN RESECTION___

WHAT MEDICATION(S) DO YOU TAKE FOR OSTEOPENIA / OSTEOPOROSIS, OR FOR YOUR "BONES"? _____

DOSAGE: _____ HOW LONG_____

MARK All THAT APPLY TO YOU:

BISHOSPHONATE_____ CALCITONIN_____ CALCIUM_____ ACTONEL_____
FLOURIDE_____ PTH 1-34_____ THIAZIDE_____ VITAMIN D_____ FOSAMAX_____

IF FEMALE PLEASE INDICATE IF: PREMENOPAUSAL_____ POSTMENOPAUSAL_____

ARE YOU PREGNANT? YES_____ NO_____