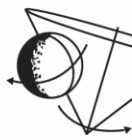


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### **DEXA (Bone Densitometry Exam)**

Patient name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

Gender: \_\_\_\_\_ Female \_\_\_\_\_ Male

HISTORY OF FRACTURES: \_\_\_\_\_ YES \_\_\_\_\_ NO Which body part \_\_\_\_\_

#### INDICATIONS: (CHECK ALL THAT APPLY)

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> OSTEOPOROSIS                                | <input type="checkbox"/> OSTEOPENIA     | <input type="checkbox"/> THYROID DISEASE      |
| <input type="checkbox"/> DIABETES                                    | <input type="checkbox"/> ARTHRITIS      | <input type="checkbox"/> AUTO IMMUNE DISORDER |
| <input type="checkbox"/> EATING DISORDER                             | <input type="checkbox"/> CORTICOSTEROID | <input type="checkbox"/> FAMILY HISTORY       |
| <input type="checkbox"/> EARLY MENOPAUSE                             | <input type="checkbox"/> AMENORRHEA     | <input type="checkbox"/> LOW TESTOSTERONE     |
| <input type="checkbox"/> HYSTERECTOMY/BILATERAL OVARIAN OOPHORECTOMY |   |   |
| _____ OTHER  |   |   |

ARE YOU TAKING ANY MEDICATIONS FOR YOUR BONES: \_\_\_\_\_ YES \_\_\_\_\_ NO

IF YOU ARE FEMALE, ARE YOU:

PREMENOPAUSAL  POSTMENOPAUSAL  PREGNANT

Patient signature/Patient Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship \_\_\_\_\_

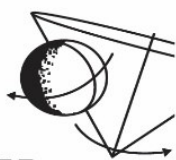
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## DEXA (Examen de Densitometría Ósea)

Nombre de paciente: \_\_\_\_\_ Fecha de nacimiento: \_\_\_\_\_

Altura: \_\_\_\_\_ Peso: \_\_\_\_\_

Género: \_\_\_\_\_ Femenino \_\_\_\_\_ Masculino

¿Antecedentes de fracturas no traumáticas?:  SI  NO      ¿Qué parte del cuerpo? \_\_\_\_\_

### INDICACIONES: (marque todas las que correspondan)

OSTEOPOROSIS                       OSTEOPENIA                       ENFERMEDAD TIROIDEA  
 DIABETES                               ARTHRITIS                               AUTO TRASTORNO  
 TRASTORNO ALIMENTARIO       CORTICOSTEROID                       ANTECEDENTES FAMILIARES  
 MENOPAUSIA TEMPRANA       AMENORRHEA                       NIVELES BAJOS DE TESTOSTERONA  
 HISTERECTOMÍA/BILATERAL RESECCIÓN OVÁRICA

¿ESTÁS TOMANDO ALGÚN MEDICAMENTO PARA TUS HUESOS:  SI  NO

SI ERES MUJER, ¿ERES:  PREMENOPÁUSICA       POSMENOPAUSICA       EMBARAZADO

Firma del Paciente / Firma de Guardián del Paciente: \_\_\_\_\_ Fecha: \_\_\_\_\_

Relación \_\_\_\_\_