raleigh radiology

BMD (DEXA) History

Patient: _____ Today's Date: ____/_____/_____

Date of Birth: _____/_____/_____ Age: _____ Referring MD: _____

Primary Doctor, if different: _____ SEX: Male Female

Reason for exam: _____

List all medications you are currently taking: including over the counter and herbals : _____

_____

Race: African American Asian Caucasian Hispanic **Height:** _____ft. _____in. **Weight:** _____ lbs.

Have been diagnosed and treated for osteoporosis?	Y	N	Have you ever been diagnosed with Anorexia/Bulimia?	Y	N
Have you ever been diagnosed with secondary osteoporosis?	Y	N	Do you do weight bearing exercises regularly?	Y	N
Do you smoke tobacco?	Y	N	Have you ever taken prednisone or any Glucocorticoid for more than 3 months?	Y	N
Do you drink more than 3 alcohol units per day?	Y	N	Have you ever taken estrogen, progesterone, or HRT? If yes, for how long: _____	Y	N
Do you drink caffeinated beverages regularly?	Y	N	Have you been diagnosed with a thyroid disorder?	Y	N
Is your diet low in dairy products and other sources of calcium?	Y	N	Have you been diagnosed with hyperparathyroidism?	Y	N
Do you take calcium supplements and/or Vitamin D? If yes, how many Mgs? _____	Y	N	Do you take thyroid medications regularly?	Y	N
Are you post-menopausal? (post-menopausal means you **have not had a period in one full year**) **Date of last period**: _____ **Age of first period**: _____	Y	N	Have you ever been diagnosed with seizure/convulsion disorders?	Y	N
Have you ever missed a period for more than 6 months? (Not including menopause/pregnancy)	Y	N	Do you take a convulsion or anti-seizure medications?	Y	N
Have you had a hysterectomy?	Y	N	Have you ever been diagnosed with an inflammatory bowel disease?	Y	N
Do you still have your ovaries?	Y	N	Have you been diagnosed with rheumatoid arthritis?	Y	N
Have you ever fractured or had surgery of your hip(s)?	Y	N	Have you ever been diagnosed with end stage renal disease?	Y	N
Have you ever fractured or had surgery of your spine?	Y	N	Have you ever been diagnosed with any type of cancer? Type:_____	Y	N
Have you ever fractured or had surgery of your wrist(s)?	Y	N	Have you ever been diagnosed with asthma or emphysema?	Y	N
Have you had other fractures not from trauma since age 40?	Y	N	Have you ever had a Bone Density test before? If yes, list date and location:	Y	N
Have either parent ever fractured a hip?	Y	N	Have you had any nuclear medicine or Barium x-rays in the past 72 hours?	Y	N
Number of full term pregnancies? _____			What is the tallest height you have ever been? _____		

BMD Totals (for technologist's use only)

Indication/History: _____

Patient BMI_____

	Today's Date: _____		Prior Date: _____	
	BMD (g/cm2)	**T-Score**	**BMD (g/cm2)**	**T-Score**
L1 – L4				
RT NECK				
Total RT				
LT NECK				
Total LT				

FRAX Assessment

Major Osteoporotic Fracture: _____%

Hip Fracture: _____%

Technologist's Signature: _____