San Gabriel Valley
Diagnostic Center
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# BONE DENSITOMETRY (DEXA)
## PATIENT HISTORY

NAME: ____________________ DATE: ____________________

DATE OF BIRTH: ____________________ FILE NO: ____________________

SOCIAL SECURITY #: ______ ___ ______ ZIP CODE: ____________________

REFERRING PHYSICIAN: ____________________ AGE: ____________________

ETHNIC GROUP: (Please check √ one)

White________ Black__________ Hispanic__________ Oriental__________ American Indian__________

HEIGHT ______ ft. ______ ins.

WEIGHT ____________ lbs.

1 Is this your first Bone Density (DEXA) exam?

☐ Yes ☐ No

Date of last exam: ____________________

2 Have you had a **Nuclear Medicine** (isotope) or **contrast exam** (CT with contrast, upper GI, barium swallow, Barium enema, small bowel series) in the past 7 days?

☐ Yes ☐ No

If Yes, please list exam(s): ____________________

3 Have you had surgery on your hip or spine?

☐ Yes ☐ No

4 Have you ever fractured your hip(s) or spine?

☐ Yes ☐ No

5 Which is your dominant side?

☐ Right (hand) ☐ Left (hand)

6 Do you have a known curvature of the spine (scoliosis)?

☐ Yes ☐ No

7 Are you post-menopausal?

☐ Yes ☐ No

8 At what age did your menopause begin? ____________________

9 Have you had a post-menopausal bone fracture?

☐ Yes ☐ No

10 Do you take a hormone (estrogen) replacement?

☐ Yes ☐ No

If Yes, how many years? ____________________

11 Do you take any calcium supplements?

☐ Yes ☐ No

If Yes, did you take any calcium or multi-vitamin today? ________