SOUTHWEST MEDICAL IMAGING

DEXA BONE DENSITY HISTORY

Name: **Date:** **Accession:**

Have you taken any calcium supplements in the last 24 hours? ◯ **Yes** ◯ **No**

Have you had nuclear medicine, oral, or IV contrast exams within the past 10 days? ◯ **Yes** ◯ **No**

Have you been diagnosed with osteoporosis or osteopenia by a physician? ◯ **Yes** ◯ **No**

Ethnicity:

Caucasian: ◯ **Yes** ◯ **No** **Hispanic:** ◯ **Yes** ◯ **No**

African American: ◯ **Yes** ◯ **No** **Asian:** ◯ **Yes** ◯ **No**

Other:

Current Height: **Tallest Height:**

Weight: ◯ **Right-Handed** ◯ **Left-Handed**

If applicable:

Premenopausal: ◯ **Yes** ◯ **No**

Perimenopausal: ◯ **Yes** ◯ **No**

Postmenopausal: ◯ **Yes** ◯ **No**

Age at Menopause:

Total Hysterectomy(Uterus and ovary removed): ◯ **Yes** ◯ **No**

Partial Hysterectomy (Uterus removed): ◯ **Yes** ◯ **No**

Age at time of hysterectomy:

Please Indicate Prior Surgeries:

Back/Spinal Surgery: ◯ **Yes** ◯ **No**

Hip Surgery: ◯ **Yes** ◯ **No**

Wrist Surgery: ◯ **Yes** ◯ **No**

Vertebroplasty/Kyphoplasty: ◯ **Yes** ◯ **No**

Please Indicate Previous Fractures:

Spinal Compression Fracture:	◯ **Yes** ◯ **No**
How:	
Hip Fracture:	◯ **Yes** ◯ **No**
How:	
Wrist/Distal Radial Fracture:	◯ **Yes** ◯ **No**
Sacral Insufficiency Fracture:	◯ **Yes** ◯ **No**

Have you taken any of the following medications in the past 12 months?

Evista (raloxifene):	◯ **Yes** ◯ **No**	**Forteo (parathyroid hormone):**	◯ **Yes** ◯ **No**
Evenity (Romosozumab-aqqg):	◯ **Yes** ◯ **No**	**Miacalcin (calcitonin):**	◯ **Yes** ◯ **No**
Hormone Replacement Therapy:	◯ **Yes** ◯ **No**	**Prolia, Xgeva (denosumab):**	◯ **Yes** ◯ **No**
Reclast (zoledronate):	◯ **Yes** ◯ **No**	**Tymlos (abaloparatide):**	◯ **Yes** ◯ **No**

Have you taken any of the following medications in the last 2-24 months?

Actonel (risedronate):	◯ **Yes** ◯ **No**	**Boniva (ibandronate):**	◯ **Yes** ◯ **No**
Fosamax (alendronate):	◯ **Yes** ◯ **No**	**Zometa:**	◯ **Yes** ◯ **No**

Have you ever had a bone fracture (excluding skull, hands, and feet) over the age of 40, not caused by trauma?	◯ **Yes** ◯ **No**
Have either of your biological parents suffered a HIP fracture not caused by trauma?	◯ **Yes** ◯ **No**
Do you currently smoke anything including vaping? **(TODAY)**	◯ **Yes** ◯ **No**
Have you ever taken ORAL (not inhaler) steriods? **(5mg or more daily for more than 3 months**)	◯ **Yes** ◯ **No**
Have you been diagnosed by a physician with Rheumatoid Arthritis?	◯ **Yes** ◯ **No**
Do you have 3 or more alcoholic drinks **every** day?	◯ **Yes** ◯ **No**
Do you take thyroid medication?	◯ **Yes** ◯ **No**