SMIL MEDICAL IMAGING
AFFILIATED WITH SOUTHWEST DIAGNOSTIC IMAGING LTD.

DEXA BONE DENSITY HISTORY

NAME: _____ DATE OF BIRTH: _____ DATE: _____

Have you been diagnosed with osteoporosis or osteopenia by a physician? Yes ____ No ____
Have you experienced height loss greater than 2 inches since young adulthood? Yes ____ No ____

Ethnicity:
Caucasian ____ Asian ____ African American ____ Hispanic ____ Other _____

Height: _____ Weight: _____ Right or Left Handed: _____

Female:
Premenopausal: Yes ____ No ____
Perimenopausal: Yes ____ No ____
Postmenopausal: Yes ____ No ____
Age at Menopause: _____
Partial Hysterectomy(Uterus removed): Yes ____ No ____
Total Hysterectomy(Uterus & ovary removed): Yes ____ No ____

Male:
History of Prostate cancer: Yes ____ No ____
If so when: _____
Orchiectomy: Yes ____ No ____
History of low testosterone: Yes ____ No ____

Please Indicate Prior Surgeries:
Back/Spinal Surgery: Yes ____ No ____
Hip Surgery: Yes ____ No ____
Wrist Surgery Yes ____ No ____
Vertebroplasty/Kyphoplasty Yes ____ No ____
Major Organ Transplant Yes ____ No ____

Please Indicate Previous Fractures:
Spinal Compression Fracture: Yes ____ No ____
How: _____
Hip Fracture: Yes ____ No ____
How: _____
Wrist/Distal Radius Fracture: Yes ____ No ____
How: _____
Sacral Insufficiency Fracture: Yes ____ No ____

Please Indicate If You Have Either Of The Existing Conditions:
Any Thyroid Disease Yes ____ No ____
Hyperparathyroid Disease Yes ____ No ____

Do you have a personal history of Cancer Yes ____ No ____

Have you taken any of the following medications in the past 12 months?
Evista(Raloxifene): Yes ____ No ____
Hormone Replacement Therapy: Yes ____ No ____
Prolia(Denosumab): Yes ____ No ____
Forteo(parathyroid hormone): Yes ____ No ____
Miacalcin(Calcitonin): Yes ____ No ____
Reclast(Zoledronate): Yes ____ No ____

Have you taken any of the following medications in the last 2-24 months?
Actonel(Risedronate): Yes ____ No ____
Fosomax(Alendronate): Yes ____ No ____
Boniva(ibandronate): Yes ____ No ____
Zometa: Yes ____ No ____

Have you had a bone fracture over the age of 40, not caused by trauma?(Excluding skull, hands & feet) Yes ____ No ____
Have either of your biological parents suffered a HIP fracture not caused by trauma Yes ____ No ____
Do you currently smoke? **(TODAY)** Yes ____ No ____
Have you ever taken ORAL glucocorticoids/STEROIDS? **(5mg or more daily for more than 3 months)** Yes ____ No ____
Have you ever been diagnosed by a physician with Rheumatoid Arthritis Yes ____ No ____
Do you have 3 or more alcoholic drinks every day Yes ____ No ____