SMIL
SOUTHWEST MEDICAL IMAGING
AFFILIATED WITH RADIOLOGY PARTNERS

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 ____

Have you had nuclear medicine, oral, or IV contrast exams within the past 10 days? 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 ____

Age at time of Hysterectomy: _____

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 ____

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 ____

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 ____