

INTERMOUNTAIN OSTEOPOROSIS CENTER

REPEAT DEXA SCAN

NAME: _____
ADDRESS: _____
HOME PHONE: _____

DATE: _____
PHYSICIAN: _____
DOB: _____ AGE: _____ M or F
WORK PHONE: _____

PERSONAL HISTORY

- Do you exercise regularly? Y N If yes, what activity? _____
How many minutes? _____
How many times per week? _____
- Do you drink milk? Y N If yes, how many 8 oz. glasses per day? _____
- Do you take a calcium supplement? Y N If yes, what type (carbonate or citrate)? How many milligrams (mgs) per day? _____
- Are you currently on Hormone Replacement Therapy (HRT)? Y N If yes, for how long? _____
Name: _____ Dosage: _____
- Do you take Vitamin D? Y N If yes, how many IU's per day? _____
- Do you take a multivitamin? Y N
- Do you drink alcoholic beverages? Y N If yes, how many per day? _____
- Do you drink caffeinated beverages? Y N If yes, how many ounces per day? _____
- Do you smoke? Y N If yes, how many cigarettes per day? _____
For how many years? _____
If you have quit smoking, for how many years did you smoke? _____

MEDICAL HISTORY

- Please list any new medical illnesses you have developed since your last DEXA scan.

- Please list any surgeries that you have had since your last DEXA scan.

- Please list any fractures you have had since your last DEXA scan.

- Please list all medications you are currently taking including dosage and number of times taken daily. Include vitamins and over the counter medications.

FOR OFFICE USE ONLY

Height: _____ Weight: _____
Comments: _____