

FIRST DEXA SCAN

NAME: _____

DATE: _____

ADDRESS: _____

SSN: _____

AGE: _____ M or F

HOME PHONE: _____

WORK PHONE: _____

PHYSICIAN: _____

PERSONAL HISTORY

What is your ethnic background (check one)? Caucasian Other _____

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 brand? _____

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 week? _____

Do you drink caffeinated beverages? Y N

If yes, how many ounces per week? _____

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

Current weight: _____

Height at age 30: _____

Have you ever had any of the following illnesses?

- alcoholism hyperparathyroidism angina hypothyroid asthma
- kidney stone blood clots lupus malabsorption
- osteoarthritis
- diabetes chronic liver disease stroke anorexia / bulimia heart attack
- osteoporosis Cushing's Disease ulcer rheumatoid arthritis hiatal hernia
- uterine cancer Paget's Disease breast cancer high blood pressure
- hyperthyroid chronic kidney disease

Do you have chronic back pain? Y N

If yes, what specific location? _____

Do you currently have symptoms of esophageal reflux (heartburn)? Y N

Do you have a family history of osteoporosis? Y N

If yes, who? _____

Please list all surgeries and give dates.

Please list all current and / or past fractures

<u>Location</u>	<u>Date</u>	<u>Cause</u>

For Women Only

Date of your last menstrual period: _____

Have you ever had irregular or missed menstrual periods? Y N

If yes, when? _____

Have you ever had a hysterectomy? Y N

If yes, when? _____

Have your ovaries been removed? Y N

If yes, when? _____

Have you been through menopause? Y N

If yes, age at menopause: _____

Do you currently take Estrogen? Y N

If yes, for how long? _____ Brand: _____ Dosage: _____

Have you ever taken Estrogen? Y N

If yes, for how long? _____ Brand: _____ Dosage: _____

Do you have a family history of breast cancer? Y N

If yes, who? _____

MEDICATION HISTORY

Please list all medications to which you are allergic or intolerant and the reaction caused.

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

Have you ever taken any of the following medications?

- anticonvulsants Miacalcin birth control pills steroids Coumadin
 Tamoxifen Didromel Theophylline Fosamax thyroid
meds

If yes, how long?
