

**Bone Densitometry
(DEXA)**



Patient Name: _____ **Age:** _____ **Weight:** _____ **Height:** _____

Have you had a previous Bone Densitometry study: Yes No

If yes, where was the exam done: _____ When: _____

If female, are you: Menopausal Post menopausal

If you are menopausal, for how long: _____ Years: _____

Any possibility of pregnancy: Yes No

Have you had a surgical Hystorectomy: Yes No

If yes: _____ Year: Partial Full

Have you experienced a recent change in weight: Yes No

How has the weight been: Up Down

If you smoke, how many packs per day: _____

Current medications that you are taking: Vitamins Diuretics Estrogen
 Cortisone Osteo meds Thyroid meds

List others: _____

Any recent fractures: Yes No Where: _____

Any prior lumbar spine surgery: Yes No

Any prior hip surgery: Yes No

Do you have Hypoparathyroidism: Yes No

Have you ever used steroids: Yes No

Check your ethnic group: Caucasian Asian Afro-American
 Hispanic Other: _____

Technologist initials: _____

Technologist notes: _____

Patient Signature _____ **Date** _____

► MRI
► CT
► Ultrasound
► Bone Densitometry
► Breast MRI
► Digital Mammography

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