

**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: _____

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
- ▶ X-Ray
- ▶ Ultrasound
- ▶ Bone Densitometry
- ▶ Digital Mammography
- ▶ Breast MRI

100 Commons Way
Suite 110
Holmdel, NJ 07733
TEL: 732-671-6618
FAX: 732-671-7353
www.holmdelimaging.com