Patient Sticker

Appomattox Imaging
HCAVa
AN HCA AFFILIATE

BONE DENSITY MEDICAL HISTORY

Please read carefully. Complete FRONT & BACK in its ENTIRETY

Name: _____ Height: _____ Weight: _____ lbs. Age: _____ yrs.

Race: ☐ White ☐ Black ☐ Hispanic ☐ Asian ☐ Other _____

Sex: ☐ Female ☐ Male

Are you? ☐ Right Handed ☐ Left Handed

Have you had a DEXA Bone Mineral Density exam before? ☐ Yes ☐ No

If yes, when and where: _____

Is this exam for: ☐ Osteoporosis Screening
☐ Monitoring Osteoporosis Treatment
☐ Other: _____

MENOPAUSE

(Female Patients Only)

YES	NO	
		Are you postmenopausal (Have you stopped having a period?)
		Do you have any postmenopausal symptoms? **If *YES*** – Explain: _____ **If *NO:*** Having no current problems/currently in asymptomatic postmenopausal state.
		Have you had a hysterectomy?
		Did you have both of your ovaries removed?
		Is there a chance you could be pregnant?

OSTEOPOROSIS RISK FACTORS

YES	NO	
		Do you drink three or more alcoholic drinks every day?
		Do you have a family history of Osteoporosis?
		Has either of your parents fractured their hip without major trauma?
		Do you take steroids regularly (≥5 mg of prednisone per day for at least 3 months)
		Do you have a history of fracture; hip, spine, shoulder or forearm without trauma
		Do you have a history of any of the following (***If YES***, check all that apply) ☐ Diabetes Type 1 ☐ Premature menopause (< 45) ☐ Hypothyroidism ☐ Hyperthyroidism ☐ Crohn's, Ulcerative colitis ☐ Hypogonadism ☐ Chronic antiseizure medication ☐ Breast Cancer Chemotherapy
		Have you been diagnosed with Rheumatoid Arthritis?
		Do you currently smoke tobacco?
		Have you lost two inches or more in height since high school?

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OSTEOPOROSIS

YES	NO	
☐	☐	Have you been diagnosed with Osteoporosis or Osteopenia? ***IF YES***, please circle which one
☐	☐	Are you being medically treated for Osteoporosis or Osteopenia (other than Calcium or Vitamin D)? ***IF YES***, which medication(s) are you taking and for how long? ☐ Fosamax, Fosamax plus D, Dinosto _____ ☐ Boniva _____ ☐ Actonel, Atelvia _____ ☐ Forteo _____ ☐ Miacalcin, Fortical, Calcitonin _____ ☐ Evista _____ ☐ Reclast, Zometa _____ ☐ Prolia _____ ☐ Estrogen or Hormone Replacement Therapy (list)) _____ ☐ Other: _____

OTHER INFORMATION

Do you have a removable continuous glucose-monitoring device? ☐ Yes ☐ No

Have you had ORAL contrast for a CT or X-ray procedure in the past 7 days? ☐ Yes ☐ No

Have you had prior surgery to your: (check all that apply)

☐ Right Hip ☐ Left Hip ☐ Lumbar Spine ☐ Right Wrist ☐ Left Wrist

ADDITIONAL NOTES

_____

_____

_____

I have read and completed the above questions on the Bone Density Medical History form. I have been provided the opportunity to ask any questions I may have. I verify this by signing below.

_____ _____

Patient or Authorized Representative Date

_____

If not patient, relationship to patient

FOR TECHNOLOGIST USE ONLY

By signing below, I acknowledge the following:

1. I have reviewed the above information on Bone Density Medical History form with the patient in its entirety.
2. I provided the patient an opportunity to ask any questions he/she may have.

Reviewed by/Signature: _____ Bone Density Technologist Date: _____