

Name: \_\_\_\_\_

PT ID# \_\_\_\_\_

**BONE MINERAL DENSITY (DEXA) PRE-SCAN INFORMATION**

Bone Mineral Density studies are used to establish the diagnosis of osteoporosis, assess an individual's risk for subsequent fractures and/or evaluate the response of the bone disease to treatment.

The following will be used to assess your calcium loss and fracture risk levels:

**Primary Risk Factors**

**YES NO**

- Menopause before age 40?
- Osteoporosis?
- Hyperparathyroidism?
- Recent fracture of the spine, hip pelvis or other long bone?.....List: \_\_\_\_\_
- Bone fractures after the age of 18? ..... List: \_\_\_\_\_
- Heparin/Coumadin therapy?.....Number of years \_\_\_\_\_
- Anticonvulsant meds for seizures or epilepsy?...List \_\_\_\_\_ #of years \_\_\_\_\_
- Steroid Treatments? ..... List \_\_\_\_\_ #of years \_\_\_\_\_
- Prescription meds for Osteoporosis? .....List \_\_\_\_\_ #of years \_\_\_\_\_

**Personal Medical History**

**YES NO**

- Ovaries removed before menopause?
- Chronic gastrointestinal disorders?
- Hyperthyroid? (Overactive thyroid)
- Hypothyroid? (Under active thyroid)
- Insulin dependant Diabetes?
- Has your menstrual cycle ever ceased due to excessive athletic activity?
- Have you ever had an eating disorder, or consumed too little nutritious food?
- Do you have a family history of Osteoporosis or other bone disease?
- Postmenopausal? If not, what was the first day of your last menstrual cycle? \_\_\_\_\_
- Spine or Hip surgery? (Please circle one). When? \_\_\_\_\_
- Partial or Total Hysterectomy? (Please circle one). When? \_\_\_\_\_
- Personal history of Cancer? Breast, Lung, Prostate, other: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_
- Chemotherapy? When? \_\_\_\_\_
- Rheumatoid Arthritis?
- Hormone Replacement Therapy, past or present?..... List \_\_\_\_\_ #of years \_\_\_\_\_
- Thyroid meds?..... #of years \_\_\_\_\_
- Diuretic?..... List \_\_\_\_\_ #of years \_\_\_\_\_
- Do you currently smoke?
- <127 pounds?
- First degree relative with bone fracture as an adult?
- Long-term DepoProvera use, <5 years?
- Weight change of more than 10 pounds since last DEXA scan?

Signature \_\_\_\_\_

Date \_\_\_\_\_