Dakota Radiology

DXA History Form

Name:		**Today's Date:**	
Patient ID:		**Sex:**	○ F ○ M
Current Height: (in)		**Date of Birth :**	
Weight: (lb)		**Referring Physician:**	
Ethnicity:			

What was your maximum height (inches) ?

Have you had previous hip or spine surgery? ○ Yes ○ No

Have you had any fractures(broken bones) during your adult life which did not result from significant trauma(e.g.,auto accident)? ○ Yes ○ No

Do you smoke? ○ Yes ○ No

Do you drink 3 or more alcoholic beverages per day? ○ Yes ○ No

Do you have family history of osteoporosis? ○ Yes ○ No

Have either of your parents ever had a broken hip/hip fracture? ○ Yes ○ No

Do you perform weight bearing exercise regulary? ○ Yes ○ No

Do you regularly consume dairy products(e.g.,cheese, milk)? ○ Yes ○ No

Do you drink caffeinated beverages? ○ Yes ○ No

Medication List

Have you ever taken or are currently taking any of the following medications for your bones:

☐ Actonel	☐ Boniva	☐ Reclast
☐ Evista	☐ Fosamax/Alendronate	☐ Forteo
☐ Prolia	☐ Calcium	☐ Vitamin D

Have you ever taken Glucocorticoids(e.g., Prednisone or Cortisone) for more than 3 months continuously? ○ Yes ○ No

Do you take Thyroid Medication (e.g.,synthroid or levothyroxine)? ○ Yes ○ No

Do you take medications for any seizure disorder? ○ Yes ○ No

Medical Conditions

Do you currently have or have you ever been diagnosed with Cancer? ○ Yes ○ No

Type of Cancer:

Do you have Rheumatoid Arthritis? ○ Yes ○ No

Have you been diagnosed with Hyperparathyroidism? ○ Yes ○ No

Do you have any of the following medical conditions:

- ☐ Anorexia or Bulimia
- ☐ Asthma or Emphysema
- ☐ Renal Failure/End Stage Renal Disease
- ☐ Inflammatory Bowel Disease
- ☐ Hypogonadism
- ☐ Osteogenesis Imperfecta
- ☐ Malabsorption
- ☐ Chronic Liver Disease
- ☐ Chronic Malnutrition
- ☐ Organ Transplant
- ☐ Type 1 Diabetes
- ☐ ______

Females:

At what age did your period start? ______

Are you premenapausal? ○ Yes ○ No

Are you pregnant? ○ Yes ○ No

At what age did you go through menapause? ______

How many full term pregnancies have you had? ______

Have you had a hysterectomy? ○ Yes ○ No

Have you had both ovaries removed? ○ Yes ○ No

Do you currently take oral estrogen(HRT) or have you in the past? ○ Yes ○ No

At what age did you start oral estrogen(HRT)? ______

At what age did you stop oral estrogen(HRT)? ______

Tech Comments

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