University Diagnostic Institute
Winter Park • Longwood • Orlando

TECHNOLOGIST USE ONLY

Measured Weight _____ lbs	Measured Height _____ft _____in
Tech Signature	Date / /

DEXA SCREENING FORM

Last Name	First Name		Phone ( )	
☐ Female ☐ Male	D.O.B / /	Age	Height	Weight
Emergency Contact			Phone ( )	

Reason for DEXA scan today?_____

Symptoms related to Injury? ☐ YES ☐ NO ☐ Auto Accident? ☐ Work Related? ☐ Other? Date: _____

Please list/describe symptoms you are experiencing:_____

What is your ethnicity? **This information is necessary for the software to analyze your scan**

☐ Caucasian ☐ African-American ☐ Asian ☐ Hispanic ☐ Other_____

Are you or do you suspect that you are pregnant? ☐ YES ☐ NO

Have you had any exam using ingested barium within the past 7 days? ☐ YES ☐ NO

If YES, do not continue with this questionnaire. Return all forms to the receptionist and a technologist will speak with you shortly.

PATIENT HISTORY

Which hand do you write with? ☐ LEFT ☐ RIGHT

Have you had a DEXA (Bone Density) scan in the past? ☐ YES ☐ NO

If YES, When:_____ Where?_____

Have you had prior surgery to your hip(s) or spine? ☐ YES ☐ NO

If YES, please explain._____

Female patients only: Have you gone through menopause? If YES, at what age? _____ ☐ Natural ☐ Surgical

Do you have a family history of osteoporosis/osteopenia? ☐ YES ☐ NO

Do you currently smoke cigarettes? ☐ YES ☐ NO

Do you have a condition known to be associated with bone loss? ☐ YES ☐ NO

(e.g. diabetes, absorption disorder, premature menopause, crohn's disease)

Previous fracture? ☐ YES ☐ NO

Parent Fractured Hip? ☐ YES ☐ NO

Alcohol Consumption? ☐ YES ☐ NO ☐ 3+ units/day

Rheumatoid Arthritis? ☐ YES ☐ NO

Glucocorticoids? ☐ YES ☐ NO

CURRENT MEDICATIONS

HRT (Hormone Replacement Therapy)? ☐ YES ☐ NO

Calcium and/or Vitamin D supplements? ☐ YES ☐ NO

Corticosteroids (Steroid Hormones)? ☐ YES ☐ NO

Depo-Provera? ☐ YES ☐ NO

Anticonvulsants (Seizure medications)? ☐ YES ☐ NO If YES, name of medication? _____

Thyroid Medications? ☐ YES ☐ NO If YES, name of medication? _____

Are you currently taking prescription medication for osteoporosis/osteopenia? ☐ YES ☐ NO If YES, how long?_____

Check all medications that apply:

☐ Fosamax ☐ Actonel ☐ Calcitonin (Miacalcin) ☐ Boniva ☐ Evista ☐ Reclast ☐ Forteo (PTH) ☐ Other_____

PATIENT SIGNATURE

I attest that the answers I have provided on this form are correct to the best of my knowledge. I have read and understand the contents of this form and I have had the opportunity to ask questions regarding the information on this form.

_____ _____

PATIENT/PARENT/LEGAL REPRESENTATIVES SIGNATURE **DATE**

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