SDMI STEINBERG DIAGNOSTIC

Intake & History Questionnaire
Dexascan

Patient Information Patient Number _____ *to be filled in by tech*

First Name _____ Last Name _____ Age _____

Ethnicity _____ Weight _____ Height _____

Reason for your Exam *(please describe in detail)*

_____

HISTORY (circle YES or NO for each)

Are you here for a Post Menopausal Osteoporosis Screening? YES NO

Are you taking any bone loss medications (Boniva, Fosamax, other)? YES NO Name: _____

Is there a chance that you are pregnant?			YES NO
Have you had a barium X-Ray in the last 2 weeks?			YES NO
Have you had a nuclear medicine test or dye injection X-Ray in the last 2 weeks?			YES NO

If you circled yes for ANY of the above you must verbally NOTIFY the tech before your exam.

Have you ever had a bone density test?	YES	NO	When/Where: _____
Have you been diagnosed with Osteoporosis?	YES	NO	When: _____
Have you been diagnosed with low bone mass (osteopenia)?	YES	NO	When: _____
Do you take/have taken estrogen or hormone replacement?	YES	NO	Type/Dose/When: _____
Are you taking calcium/vitamin D	YES	NO	When: _____
Have you ever had surgery of the spine, hips, or arms?	YES	NO	
Do you have any metal in your backs or hips?	YES	NO	
A family history of hip fracture in mother or father?	YES	NO	
Taken steroid pills for 3 months or more (glucocorticoids)?	YES	NO	
History of a fracture as an adult?	YES	NO	
Ever diagnosed with a secondary osteoporosis?	YES	NO	
Ever diagnosed with rheumatoid arthritis?	YES	NO	
Are you a current smoker?	YES	NO	
Do you consume more than 3 alcoholic drinks per day?	YES	NO	

WOMEN ONLY (circle YES or NO for each)

Are you still having menstrual periods?	YES	NO	
Are you postmenopausal?	YES	NO	At what age? _____
Have you had a hysterectomy (removal of uterus)?	YES	NO	At what age? _____
Have you had both of your ovaries removed?	YES	NO	

Previous surgeries, recent hospitalization, imaging studies and other important medical conditions

(Please list specifically, what and when. Use back if extra space needed.)

Procedure Description Date

_____ _____

_____ _____

Patient Signature: _____ **Todays Date:** _____

TECH NOTES: *(for internal use only)*

Notes _____