DXA History

AdventHealth

Print Name: _____ Date: _____ Age: _____

Birth date: _____ Height: _____ Weight: _____ Are you right or left handed? ☐ Right ☐ Left

Ethnicity: ☐ Caucasian ☐ African-American ☐ Hispanic ☐ Asian

Previous DXA scan? ☐ Yes ☐ No If yes, When: _____ Where: _____

PLEASE CHECK ANY OF THE FOLLOWING MEDICATIONS YOU ARE CURRENTLY TAKING:

☐ ACTONEL (Risedronate)
☐ AREDIA (Intravenous Pamidronate)
☐ ARIMIDEX (Anastrozole)
☐ BONIVA (Ibandronate)
☐ EVISTA (Raloxifene)
☐ FORTEO or PTH (Teriparatide)
☐ FOSAMAX (Alendronate)
☐ MIACALCIN (Calcitonin)
☐ PROLIA (Denosumab)
☐ RECLAST (Intravenous Zoledronic acid)
☐ OTHER (Bone Density Medications Only) _____
☐ STEROID MEDICATION (name, strength (mg), length of time (months/years) _____

PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING:

☐ Spinal Fracture Date: _____ Describe: _____
☐ Spinal Surgery Date: _____ Describe: _____
☐ Hip Fracture Date: _____ Describe: _____
☐ Hip Surgery Date: _____ Describe: _____

FEMALE PATIENTS ONLY:

Pregnant or possibly pregnant? ☐ Yes ☐ No

☐ Premenopausal, last menstrual period _____
☐ Current menopausal symptoms _____
☐ Postmenopausal, age of onset _____
☐ Hysterectomy Date: _____
☐ Ovaries removed? ☐ None ☐ One ☐ Both

_____ _____ _____ _____ _____
Patient/Legally Authorized Person Signature | Printed Name | Title (Self, Nurse, Caregiver, etc.) | Date | Time

_____ OR ☐ Phone ☐ Video _____ _____ _____
Qualified Staff / Interpreter Signature | Print Qualified Staff / Interpreter Name | ID Number | Language Interpreted

Technologist only below this line:

FRAX (Age 40 - 90) *(Ask patient the following questions, check boxes that apply)*

☐ Have you had a spontaneous fracture between ages 40-90? Describe: _____
☐ Has your mom or dad had a fractured hip?
☐ Are you a current smoker?
☐ Do you drink 3 or more alcoholic beverages per day?
☐ Do you have Rheumatoid Arthritis?
☐ Have you taken oral steroids (5mg) for 3 consecutive months any time in your life?

Secondary Osteoporosis:

☐ Do you have Diabetes Type I (insulin dependent)?
☐ Do you have Hyperthyroidism?
☐ Do you a chronic liver disease?
☐ Do you have Crohn's disease or other malabsorption conditions?
☐ Did you start menopause before age 45?

☐ BASELINE DXA
☐ FIRST DXA AT FH
☐ FOLLOW-UP DXA (Comparison Included)
☐ PREMENOPAUSAL
☐ PERIMENOPAUSAL
☐ POSTMENOPAUSAL

_____ _____ _____ _____
Technologist Authentication | OPID | Date | Time

Patient Label or
MRN _____