ChristianaCare

ENCBASFRM

Cecil Campus

BONE DENSITY SCAN (DEXA) HISTORY

Instruction:
To be completed by patient.

Sex: ☐ Male ☐ Female

Height: _____ Weight: _____

Race (mark all that apply): ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Other race: _____

Have you broken any bones as an adult? ☐ Yes ☐ No
If yes, please list bones: _____

Was the break because of an accident or trauma? ☐ Yes ☐ No

Do you have a family history (mother or father) of a broken hip? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No

Have you had surgery to remove your ovaries? ☐ Yes ☐ No

What age did you complete menopause? _____

Have you had problems with:

Kidney failure	☐ Yes	☐ No	Rheumatoid arthritis	☐ Yes	☐ No
Crohn's disease	☐ Yes	☐ No	Anorexia/bulimia	☐ Yes	☐ No
Hyperthyroidism	☐ Yes	☐ No	Alcohol abuse	☐ Yes	☐ No
Hyperparathyroidism	☐ Yes	☐ No	Liver disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Cushing's disease	☐ Yes	☐ No
Do you use insulin	☐ Yes	☐ No	Have you had chemotherapy	☐ Yes	☐ No

Do you take the following medications? ☐ Seizure medicine ☐ Lithium ☐ Calcium
☐ Vitamin D ☐ Hormone replacement

Have you ever taken steroids longer than a 3-month period? ☐ Yes ☐ No

Do you take medication for Osteoporosis? ☐ Yes ☐ No
If yes, what type: _____

Signature of Patient or Decision Maker	Relationship to Patient	Date	Time
_____	_____	___/___/___	_____

Interpretation: The information has been presented to the: ☐ Patient ☐ Representative ☐ Decision Maker in: _____ Language
The person who provided the interpretation is a qualified medical interpreter.

Interpreter Name	Agency and ID# (if applicable)
_____	_____

Witness Signature/Title	Print Name or ID#	Date	Time
_____	_____	___/___/___	_____