

DEXA Scan Patient Information

Patient Name _____ Date of Visit: _____

Date of Birth _____ Age _____ Physician: _____

Height _____ ft _____ in Weight _____ lb Ethnic Background _____ Gender: > M > F

YES NO

- > > Do you have a previous history of osteoporosis or osteopenia?
- > > Have you fractured any bones? If so, which bone & when: _____
- > > Have you had any height loss? If so, how much? _____
- > > Are you taking calcium supplements? If so, how many milligrams per day?
- > > Have you ever taken Corticosteroids or Prednisone? If so, over what period: _____
- > > Have you taken a calcium supplement in the past 34 hours?
- > > In the last week, have you had an x-ray or nuclear medicine study that required barium or contrast?
- > > Have you ever had surgery on the hips or lumbar spine? If so, list: _____

Circle any of the following conditions that you have had in the past:

Asthma	Cancer of the Breast	Cancer of the Uterus	Diabetes
Lupus	Rheumatoid Arthritis	Thyroid Problems	Osteo Arthritis
Chronic Renal Failure	Anorexia	Bulimia	Hyperparathyroid

Circle any of the following medications that you are presently taking:

Fosamax

Evista

Actonel

Miacalcin

For women only:

>	>	Do you have regular periods?
>	>	Are you post-menopausal? If yes, age of menopause: _____
>	>	Have you had a hysterectomy? If so, date: _____ Number of Ovaries: _____
>	>	Have you had any height loss? If so, how much? _____
>	>	Is there any chance you could be pregnant? Date of last period: _____

Waiver of Liability

Crossroads Medical Associates will make every attempt to have the DEXA scan reimbursed by your insurance company. In the event that the DEXA scan is considered routine or otherwise not payable by your insurance company, we will bill the patient for the DEXA scan. By signing this form, the patient or responsible party agrees to pay Crossroads Medical Associates for the DEXA scan in the event that the insurance company refuses payment.

Patient / Responsible Party Signature _____ **Date** _____