Texas Health Presbyterian Hospital®
FLOWER MOUND

DEXA SCREENING

NAME: _____

REFERRING DOCTOR: _____

Height: _____ Weight: _____ Sex: M F Date of Birth: _____

Race: White _____ Black _____ Asian _____ Hispanic _____ Other _____

Is there any possibility that you could be pregnant? Yes _____ No _____

If pregnant, how many weeks? _____ First day of your last menstrual period? _____

Have you had any barium studies done in X-ray in the last week? Yes _____ No _____

Have you had any nuclear medicine scans or CT scans in the last week? Yes _____ No _____

Indicate if you have been treated at any time for fractures of:

spine _____ right hip _____ left hip _____ other _____

Have you ever had back surgery? Yes _____ No _____

Have you had hip surgery? Yes _____ No _____

Indicate if you have been treated for any of the following:

Osteoporosis	_____
Osteopenia	_____
Kidney disease	_____
Overactive thyroid	_____
Overactive parathyroid	_____

Do your regular medications include any of the following?

Anticonvulsants	_____
Calcium supplements	_____
Estrogen replacement	_____
Fosamax	_____
Steroids	_____

Are you pre-menopausal _____ peri-menopausal _____ post-menopausal _____ N/A _____

Patient's Signature: _____ Date: _____

Technologist: _____ Prior Studies: Yes No