

MALE DEXA SCREENING

NAME: _____

REFERRING DOCTOR: _____

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

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

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 _____

Patient's Signature: _____ Date: _____

Technologist: _____

Prior Studies: Yes No