

NAME _____ DATE _____

ADDRESS _____

CITY/STATE/ZIP _____

DOB _____ AGE _____ SEX _____

REFERRING DOCTOR _____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

- 1. HAVE YOU EVER HAD A BONE DENSITY (DEXA) SCAN IN THE PAST? YES NO
- 2. IS THERE ANY CHANCE YOU MAY BE PREGNANT? YES NO
- 3. HAVE YOU GONE THROUGH MENOPAUSE? YES NO
- 4. IF YES, PLEASE INDICATE AGE AT ONSET: _____
- 5. ARE YOU RIGHT HANDED OR LEFT HANDED? RIGHT LEFT
- 6. HAVE YOU EVER HAD SURGERY ON YOUR HIPS OR SPINE? YES NO
IF YES, PLEASE INDICATE LOCATION: _____
- 7. HAVE YOU TAKEN OR ARE YOU NOW TAKING ANY STEROID MEDICATIONS? YES NO
- 8. HAVE YOU TAKEN OR ARE YOU NOW TAKING ANY HORMONE REPLACEMENT
MEDICATIONS (INCLUDING BIRTH CONTROL)? YES NO

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

FOR TECH USE ONLY	
ACCT	_____
HEIGHT	_____
WEIGHT	_____
TECH INITIALS	_____