Breast Imaging Specialists

DEXA Patient History Form

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Dipa H. Patel, MD

Softer mammogram™ PROVIDER

Name: _____ Date of Birth: _____

Sex: **M** ☐ **F** ☐ Height : _____ Weight: _____ Age at Menopause: _____

Race: African American ☐ Asian ☐ Caucasian ☐ Hispanic Other ☐

Are you taking any of the following medications?

- ☐ Hormone Replacement
- ☐ Calcium Supplements
- ☐ Vitamin D / Multivitamins
- ☐ >3 months of steroid use
- ☐ Other bone density meds
- ☐ Heparin
- ☐ Chemotherapy
- ☐ Fosemax
- ☐ Tamoxifen
- ☐ Miacalcin spray (Calcitonin)
- ☐ Lithium
- ☐ Actonyl
- ☐ Lasix
- ☐ Seizure medications
- ☐ Testosterone

Check box if any of the below are true:

- ☐ I exercise >2 times a week
- ☐ I drink 3 or more alcoholic drinks/day
- ☐ I currently smoke
- ☐ I have had a hysterectomy/oopherectomy
- ☐ I could be pregnant
- ☐ I have fractured bones after 40 in the back, hip, or wrist
- ☐ Family history of osteoporosis
- ☐ Either biological parent has fractured a hip
- ☐ I have had a Depo-Provera shot
- ☐ I have had Rheumatoid arthritis
- ☐ I have had resection of the stomach or gut/malabsorption
- ☐ I have kidney failure
- ☐ I have had a metallic pin/joint replacement in the back, hip, or wrist
- ☐ I have had a barium study, CT scan with oral contrast, or been injected with IV nuclear medication in the last 2 weeks

Are you left or right handed? L ☐ **R** ☐

Patient Signature: _____ Date: _____

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