Health Village Imaging
A Member of the Hackensack Meridian Health Network

**PATIENT NAME**:_____**DATE OF BIRTH**:_____

Height (ft)(in): _____Weight_____

Previous DEXA? Where/When?_____

Postmenopausal? What age?: _____

Rheumatoid Arthritis? YES NO

One/both ovaries removed? When?: _____

Hysterectomy? When? _____

List all broken bones since age 40: _____

Spine surgery? Describe: _____

Hip surgery? What side? Describe: _____

Wrist surgery? What side? Describe: _____

Diabetic? What type?: _____

| | | |
|---|---|---|
| Past diagnosis of osteoporosis or osteopenia? | **YES** | **NO** |
| Do you exercise regularly? | **YES** | **NO** |
| Family member with height loss? | **YES** | **NO** |
| Have you lost 2+ inches in height? | **YES** | **NO** |
| Do you have a history of smoking? | **YES** | **NO** |
| Do you have 3+ alcohol drinks per day? | **YES** | **NO** |
| Do you have multiple Myeloma? | **YES** | **NO** |
| Do you have Malabsorption or Malnutrition? | **YES** | **NO** |
| Did your mother or father have a broken hip? | **YES** | **NO** |
| Do you have Osteogenesis Imperfecta? | **YES** | **NO** |
| Do you have a family member with osteoporosis? | **YES** | **NO** |

**Do you have any of the following conditions?** ***Circle one***

Hyperparathyroidism Hypogonadism Chronic Liver Disease

**Do you take any of the following medications?** ***Circle one***

Boniva Calcium Vitamin D Calcitonin Miacalcin Estrogen
Fosamax Reclast Progesterone Long time steroids Dilantin Prolia

***I will inform the technologist if there is a possibility of pregnancy or if I recently had a barium exam or received an injection of contrast material for a CT scan or radioisotope exam.***

PATIENT SIGNATURE:_____ DATE:_____