*****NOTE: Insurance may only cover this test *ONCE EVERY 2 YEARS.* *****
Please bring the completed form with you to your appointment.

DEXA / BONE DENSITY TEST

NAME:____

REFERRING DOCTOR:____

~Have you **EVER** had a DEXA / BONE DENSITY TEST? YES or NO
*If YES, when was your last bone density test?_____________________________
*Where was your last bone density test? _________________________________

~ Have you broken a bone in your **ADULT** life? YES or NO
*If YES, at what age_____ How did it happen? ___________________________

~ Is there a history of hip fracture with either of your biological parents? YES or NO

~ Do you currently smoke? YES or NO

~ Do you drink 3 or more alcohol drinks daily? YES or NO

~ Are you **currently** taking an oral steroid? (ex: prednisone) YES or NO
*If YES what are you taking?____
*How long have you been taking it?____________________________________

~ Have you **ever** been exposed to an oral steroid (ex: prednisone) for longer than 3 months?
YES or NO
*If YES, what did you take?____
*When did you take it?____
*What was the average daily dose?_____________________________________

~ Have you had a confirmed diagnosis of Rheumatoid Arthritis? YES or NO

~Have you ever been diagnosed with any of the following: (**please write YES or NO**)
*Type 1 Diabetes:____
*Long-Standing Hyperthyroidism:_______________________________________
*Hypogonadism (low testosterone):______________________________________
*Chronic Malnutrition:____
*Chronic Liver Disease:____

~**FEMALES**- Have you reached Menopause? YES or NO
*If YES, at what age?__________________

OFFICE USE ONLY:________________ DR: __________________________

DATE: _________________
WEIGHT:_______________
HEIGHT:_______________
AGE: __________________

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