BRIGHT LIGHT RADIOLOGY

a complete imaging facility

Bone Densitometry

Dexa Scan

Date of Exam: _____ **Medical Record No:** _____

Patient Name: _____ **Date of Birth:** _____

Referring Physician: _____

Race (Please Check One):

☐ Afro-American ☐ Caucasian ☐ Native American ☐ Oriental ☐ Other

1. Have you fractured any bones during your adult life? ☐ Yes ☐ No
   If yes, please list what bones? _____
2. Is there a family history of osteoporosis? ☐ Yes ☐ No
3. Do you smoke more than ½ a pack of cigarettes per day? ☐ Yes ☐ No
4. Have you smoked in the past? ☐ Yes ☐ No
5. How many servings of dairy products do you consume per day? _____
   (One Serving= 8 oz Milk, 1 oz Cheese, container of yogurt or serving of ice cream) ☐ Yes ☐ No
6. Have you consumed three or more dairy serving per day (as defined) most of your life? ☐ Yes ☐ No
7. Do you take a calcium supplement daily? ☐ Yes ☐ No
   If yes, what is the name of the supplement? _____
   How much do you take? ☐ 0- 500 mg/day ☐ 501-1000 mg/day ☐ >1000 mg/day
8. Do you exercise at least three times per week? ☐ Yes ☐ No
   What type of exercise do you do? _____
9. Do you drink more than two alcoholic drinks per day? ☐ Yes ☐ No
10. Have you taken any of the following medication? If yes, please list how long.
    a. Steroids (prednisone, cortisone, etc) _____ ☐ Yes ☐ No
    b. Thyroid medication _____ ☐ Yes ☐ No
    c. Anticonvulsants (for seizures, epilepsy) _____ ☐ Yes ☐ No
11. Please List all Medications you are on, including the dose and length of time taken:

Drug Name	Dose	How often is medication taken? (Daily, Weekly, Monthly)

Please Fill Out Other Side

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