dexascan screening form

DuPage Medical Group
DIAGNOSTIC IMAGING

Name ______________________ MRN# ______________

Exam date ______________ Date of birth ______________ Age ______________

Who is your ordering physician? ______________

At your tallest, what was your height in feet and inches? ______________

If you are still menstruating, what was the date of your last period? ______________

If passed menopause, estimate the last year you last had a menstrual period? ______________

What is your ethnicity? ______________

Have you ever been diagnosed with scoliosis? ______________

Have you ever had a previous bone density test? ______________

current list of medications

List all medications that you are currently taking, including prescription and over the counter medications. Include vitamins and mineral supplements, natural herbs or drugs, etc.

Medications	*Dose*	*Reason for Medication?*	*How often is it taken?*

medical history

Please list any known medical conditions or disease. Please list any previous bone fracture or prosthetic devices.

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social history

circle the appropriate response

Do you smoke cigarettes?	*Presently*	*Previously*	*Never*
Do you drink alcohol?	*Daily*	*Occasionally*	*Never*
Do you exercise?	*Daily*	*Occasionally*	*Never*

Patient signature ______________________ Date ______________

To be completed by the Technologist

Notes ______________________

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Height ______________ Weight ______________ Forearm length ______________