BERGEN IMAGING CENTER, P.A.
WOMEN'S IMAGING SPECIALISTS OF ENGLEWOOD

DEXA REGISTRATION FORM

TECHNICIAN INTIALS

☐ **KS** ☐ **SS** ☐ **MS**

Account #: _____ Today's Date: _____

Name: Last _____ First _____

Date of Birth: _____ Age: _____

Date of last exam: _____ Where was it performed? _____

Send the report to the following physician(s): _____

_____

_____

Are you pregnant? ☐ Yes ☐ No Date of your last menstrual period: _____

Have you had a hysterectomy? ☐ Yes ☐ No If Yes, at what age: _____

Have you had your ovaries removed? ☐ Yes ☐ No If Yes, at what age: _____

Have you experienced Menopause? ☐ Yes ☐ No If Yes, at what age: _____

In the past 7 days, have you had any of the following? ☐ N/A

☐ Barium Contrast Study ☐ CAT Scan (w/contrast) ☐ Nuclear Medicine Study ☐ Iodine Study

Place an "X" by all that apply to you: ☐ N/A

☐ Scoliosis ☐ Spinal surgery or injury:

☐ Hip surgery or injury: ☐ Left ☐ Right Any prosthesis? ☐ Yes ☐ No

☐ Had abdominal surgeries in the past

Do you have any of the following medical conditions? ☐ N/A

☐ Anorexia or Bulimia
☐ Asthma or Emphysema
☐ Bariatric (weight loss) Surgery
☐ Rapid significant weight loss
☐ Hyper**PARA**thyroidism
☐ Seizure disorders
☐ Celiac Disease
☐ Cancer
☐ End stage renal disease
☐ Gastric Bypass Surgery
☐ Diabetes
☐ Inflammatory Bowel Disease (Crohn's/Ulcerative Colitis)

☐ Other – Please specify: _____

Medications that can cause bone loss: Place an "X" on the following meds you are taking: ☐ N/A

☐ Thyroid Meds (Synthroid/Levothyroxine/Levoxyl)
☐ Blood Thinners (Coumadin/Heparin)
☐ Diuretic (Lasix/Aldactone/Dyazide/Diamox/HCTZ/Furosemide)
☐ Antacids (Maalox/Gelusil/Mylanta/Riopan/Aludrox/Omeprazole/Ranitidine/Gaviscon/Amphojel)
☐ Steroids (Prednisone/Medrol/Cortisone/Advair/Asmanex/Dulera/Symbicort/Spiriva/Proventil)
☐ Anticonvulsants (Phenytoin/Dilantin/Phenobarbital)
☐ Gonadotropins
☐ Metformin
☐ Aspirin
☐ Lithium

Treatments: Place an "X" on the medications you have EVER taken: ☐ N/A

☐ Actonel (Risedronate)
☐ Evista (Raloxifene)
☐ Fosamax (Alendronate)
☐ Calcitonin (Miacalcin)
☐ Reclast (Zoledronate)
☐ Strontium
☐ Birth Control
☐ ERT (Estrogen)
☐ HRT (Combo)
☐ PTH-1-34
☐ Boniva (Ibandronate)
☐ Prolia (Denosumab)
☐ Calcium Supplement
☐ Flouride Supplements
☐ Vitamin D
☐ Forteo (Teriparatide)
☐ Atelvia
☐ Aredia

INDICATIONS: Place an "X" by all that apply to you: ☐ N/A

☐ Taking seizure medication (anticonvulsants: example Dilantin)

☐ White ☐ Black ☐ Hispanic ☐ Asian ☐ Other _____ **(REQUIRED INFORMATION)**

☐ Chemotherapy (Past or Present) _____

☐ Radiation Therapy (Past or Present) _____

☐ Have a family history of Osteoporosis

☐ Had loss of height. If so, how many inches? _____

☐ Diagnosed with Hyperparathyroid

☐ Have a low dietary calcium intake (milk, cheese, yogurt)

☐ Have been diagnosed with ☐ Osteopenia or ☐ Osteoporosis

☐ I am prone to recurrent falls

☐ Have kidney problems
(dysfunction, failure, on dialysis or have had a transplant)

☐ Have taken steroid therapy for 3 months or longer
(Cortisone, Prednisone, Inhalers, etc.)

TECHNICIAN NOTES

FRAX: Place an "X" by all that apply to you: ☐ N/A

☐ History of fracture as an adult: ☐ Hip or ☐ Spine

Have ever broken any other bones as an adult? ☐ Yes ☐ No Which bones? _____

☐ Family history of hip fracture (parent hip fracture)

☐ Have 3 or more glasses of alcoholic beverages per day

☐ Taking Glucocorticoids

☐ Secondary Osteoporosis (Insulin dependent diabetic, Osteoimperfecta, Hyperthyroidism, untreated hypodonadism, premature menopause <45, chronic malnutrition, malabsorption, liver disease, or undergoing chemo/radiation therapy)

☐ Have been diagnosed with Rheumatoid Arthritis

☐ Current Smoker ☐ Past History of Smoking

I verify that the answers I have provided to the questions on this form are correct and understand that withholding information or inaccurate information may adversely affect the interpretation of this exam.

Patient's signature: _____ Date:_____

NOTE: If you have previous discs and/or reports with you, please give them to the receptionist before your exam.