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

DEXA REGISTRATION FORM

TECHNICIAN INTIALS

□ KS □ LM □ JV

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 □ Hyper**PARA**thyroidism □ End stage renal disease

□ Asthma or Emphysema □ Seizure disorders □ Gastric Bypass Surgery

□ Bariatric (weight loss) Surgery □ Celiac Disease □ Diabetes

□ Rapid significant weight loss □ Cancer □ 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) □ Metformin

□ Blood Thinners (Coumadin/Heparin) □ Aspirin

□ 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 □ Lithium

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

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