# DXA History Form without FRAX

Print Name: ______________________________________________ Age: _______ Birth date: ________________

Height: _______ Weight: _______ Previous DXA scan? No_____ Yes_____ If yes, When: ____________Where:________________________________

Are you right or left handed? Right____ Left____ Ethnicity: Caucasian ____ African-American ____ Hispanic____ Asian____

**PLEASE CHECK ANY OF THE FOLLOWING MEDICATIONS YOU ARE CURRENTLY TAKING:**

| MEDICATION | STRENGTH (mg) | LENGTH OF TIME (Months/Years) |
|---|---|---|
| ____ACTONEL (Risedronate) | ___________________ | _______________________ |
| ____AREDIA (Intravenous Pamidronate) | ___________________ | _______________________ |
| ____ARIMIDEX (Anastrozole) | ___________________ | _______________________ |
| ____BONIVA (Ibandronate) | ___________________ | _______________________ |
| ____EVISTA (Raloxifene) | ___________________ | _______________________ |
| ____FORTEO or PTH (Teriparatide) | ___________________ | _______________________ |
| ____FOSAMAX (Alendronate) | ___________________ | _______________________ |
| ____MIACALCIN or FORTICAL (Calcitonin) | ___________________ | _______________________ |
| ____PROLIA (Denosumab) | ___________________ | _______________________ |
| ____RECLAST (Intravenous Zoledronic acid) | ___________________ | _______________________ |
| ____STEROID THERAPY ______________________<br>Name of Medication | ___________________ | _______________________ |
| ____OTHER (Bone Density Medications Only) | ___________________ | _______________________ |

**PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING:**

____SPINAL FRACTURE Date:_______________ Describe: ______________________________________________________

____SPINAL SURGERY Date: _______________ Describe: ______________________________________________________

____HIP FRACTURE: RT LT BOTH Date: _____________ Describe: _______________________________________

____HIP SURGERY: RT LT BOTH Date: _____________ Describe: _______________________________________

**FEMALE Patients Only:**

What is your menopausal status? Premenopausal_____ Postmenopausal _____ At what age: _______
Pregnant No_____ Yes_____

Check what applies:

____HYSTERECTOMY, When: ______________________________________________

____OVARIES REMOVED: ONE or BOTH, When: ______________________________________________

____CURRENT MENOPAUSAL SYMPTOMS, Describe: ______________________________________________

_________________________________ ___________________________ _______________________ ________/________

Patient/Authorized Person Signature Printed Name Title (Self, Nurse, Caregiver, etc..) Date Time

___________________________________________ ____________________ ____________/________

Interpreter Name ID Number Date Time

***Technologist Only below this line:*** ____________________________________________________

Check what applies:

BASELINE _______ FIRST DXA AT FH _______ FOLLOW-UP (Comparison Included) ________

PREMENOPAUSAL __________ POSTMENOPAUSAL ___________

_________________________________ ____________ ___________ _________

Technologist Authentication OPID Date Time

Patient Label or

MRN_____________________