Park Avenue Radiologists, P.C.

DEXA SCAN QUESTIONNAIRE

PLEASE COMPLETE THE FOLLOWING QUESTIONNAIRE

PLACE LABEL HERE

DATE OF SERVICE: REFERRING PHYSICIAN/PHONE NUMBER:

PATIENT NAME:

Account Number: SOCIAL SECURITY #: AGE AT MENOPAUSE: _____

DOB: FEMALE / MALE (PLEASE CIRCLE)

WEIGHT: _____LBS HEIGHT: _____FT_____IN ETHNIC BACKGROUND*: _____

ARE YOU OR COULD YOU BE PREGNANT? YES NO DATE OF LAST MENSTRUAL CYCLE: _____/____/_____

IF YOU ARE PREGNANT, PLEASE NOTIFY THE TECHNOLOGIST IMMEDIATELY.

HAVE YOU HAD A BONE DENSITY EXAM BEFORE? YES NO

IF YES, WHEN _____ (MONTH YEAR) WAS IT DONE AT THIS OFFICE? YES NO

WHAT PART OF THE BODY WERE SCANNED: LUMBAR SPINE HIP OTHER _____
(PLEASE CIRCLE) (PLEASE SPECIFY)

WHAT WERE THE RESULTS OF THE STUDY?_____

_____

_____

ARE YOU TAKING ANY ANTIOSTEOPOROSIS MEDICATION? YES NO

IF YES, WHAT TYPE? _____

ARE YOU TAKING ANY THYROID MEDICATION? YES NO

LIST ANY OTHER MEDICATIONS YOU ARE TAKING:

_____

_____

_____

*This information is required when having a DEXA SCAN in order to provide a complete evaluation of the results to your referring physician. Individual patient results are compared to and correlated with results from other patients with similar age and ethnic groups.

PLEASE DIRECT ANY QUESTIONS YOU MAY HAVE TO THE TECHNOLOGIST PERFORMING YOUR TEST.

I ATTEST THAT THE INFORMATION PROVIDED ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE.

_____
SIGNATURE OF PATIENT OR GUARDIAN OR PERSON AUTHORIZED TO CONSENT FOR PATIENT

_____
DATE

TECHNOLOGIST NOTES:

TECH SIGNATURE