ECLIPSE IMAGING & PAIN MANAGEMENT CENTER

Patient Name: _____

DOB: _____ Sex: ☐M ☐F MR#: _____

X-RAY & DEXA PATIENT HISTORY

Height: _____ Weight: _____ Referring Physician: _____

Procedure/Exam: _____

All Patients:

Have you had a previous exam related to this problem? ☐Yes ☐No

If yes, explain: _____

List other Medical Problems: _____

List previous surgeries: _____

_____

Have you had a procedure using contrast or barium contrast within the last 7 day? ☐Yes ☐No

If yes, what procedure: _____

Bone Density (DEXA) Patients:

What is your ethnicity? (Please note that this information is necessary for the software to analyze your scan.)

☐Caucasian ☐African-American ☐Asian ☐Hispanic ☐Other _____

☐Yes ☐No Have you had surgery involving the lumbar spine, hip(s), forearm, or wrists?

If yes, what procedure: _____

☐Yes ☐No Have you ever been treated with chemotherapy?

☐Yes ☐No Have you every been treated with steroids?

☐Yes ☐No Do you take calcium supplements?

☐Yes ☐No Do you take medicine for bone loss? Other Medications: _____

☐Yes ☐No Do you have a family history of osteoporosis?

☐Yes ☐No Do you have a history of bone fractures?

_____ _____

Patient, Parent, or Guardian Signature Date

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