BRIGHT LIGHT MEDICAL IMAGING
MRI•CT
MAMMOGRAPHY
US•X-RAY•DEXA

CALL TO SCHEDULE: 847-616-2000 BEDFORD PARK • DARIEN • ELK GROVE VILLAGE • MELROSE PARK FAX: 847-616-9000

DEXA (Bone Density) Screening Form

Patient Name _____ DOB_____ Todays date_____

Gender: □female □male Height_____ Weight _____

Ethnicity: □ African American □ Asian □ Caucasian □ Hispanic □Other_____

Are you or do you suspect that you are pregnant? □YES □NO

Have you had any exam using oral barium in the past 7 days? □YES □NO

IF YOU ANSWERED YES TO EITHER OF THESE TWO QUESTIONS, LET YOUR TECHNOLOGIST KNOW.

Have you had a DEXA (bone density) scan before? □YES □NO
If YES, Where?_____ When?_____

Which hand do you write with? □LEFT □RIGHT

Have you had any surgery to your hips or spine? □YES □NO
If YES, please explain_____

Have you ever fractured/broken any bones as an adult? □YES □NO
If YES, Which?_____

Do you have a family history of osteoporosis? □YES □NO

Do you drink more than 2 alcoholic drinks per day? □YES □NO

Do you smoke cigarettes? □YES CURRENTLY _____ packs per day
□NOT CURRENTLY BUT DID IN THE PAST □NEVER

Females: Have you gone through menopause? □YES □NO If yes, year_____

Please check if you have any of these medical conditions:
- □End stage renal disease
- □Rheumatoid Arthritis
- □Hysterectomy

Other:
_____
_____

Have you taken any of the following medications?
- □Steroids
- □Thyroid medication
- □Anticonvulsants (for seizures)
- □Hormone Replacement Therapy
- □ Calcium/Vitamin D Supplements

Please list any other medications you currently take:
_____
_____
_____
_____

Patient Signature_____ Date_____

Technologist Initials_____ Notes_____