



Date: _____

Name: _____

Have You Had a Previous DXA Scan? Yes No

If yes, where? _____

Referred by: _____

Sent copies of DXA Report to: _____

Height _____ ft. _____ in.

Weight _____ lbs.

Age at Menopause (or Surgical)

Is there a possibility of pregnancy? Yes No

Hormone Therapy? Yes No Type _____

Family History of Osteoporosis? Yes No

Fracture: Spine Hip
 Wrist Other

Smoking _____

Alcohol _____

Steroid Therapy _____

Meds _____

Vitamins _____

Calcium _____ mg Type _____

Milk Drinker? Yes No

Dairy? Yes No Lactose Intolerance? Yes No

Physical Activity: _____