Advanced Shore Imaging Associates
2605 Shore Road
Suites 101 & 201
Northfield NJ 08225

DEXA SCREENING FORM

Patient Name_____ **Date of Birth**_____

HEIGHT_____ **WEIGHT**_____ **Ethnicity:** Asian Black Hispanic White Other _____

Have you ever had a bone densitometry screening? **YES** **NO**
Where? _____ When? _____

Please list any broken bones you've had in your adult life:
_____

Do you have any metal implants in your lower spine, hips or wrists? **YES** **NO**

Do you or any family member have a history of height loss or osteoporosis? **YES** **NO** If yes, who? _____

Have you ever had hyperthyroidism (over active thyroid)? **YES** **NO**

Do you exercise regularly? **YES** **NO**

Do you smoke? **YES** **NO**

Do you drink alcohol more than occasionally? **YES** **NO**

Please circle any of the following medications/supplements you are taking

Estrogen	Fosamax	Didonel	Boniva/Prolia
Progesterone	Calcitonin	Calcium	Osteoporosis Meds
Cortisone	Miacalcin	Vitamin D	Other_____
Prednisone	Calcimar	Dilatin	_____

FEMALE PATIENTS:
Have you experienced menopause? **YES** **NO** If so, age? _____

Have you had a hysterectomy? **YES** **NO** Date of surgery? _____

Have you had an ovary or both ovaries removed? **YES** **NO** Date of surgery? _____

Signing below indicates that you have read and understand this form and have completed it to the best of your ability

Patient or Legal Representative Signature _____