INTERMOUNTAIN IMMC MEDICAL CLINIC™ *Our specialty is you*

INITIAL DEXA SCAN

NAME: _____ *DATE:* _____

ADDRESS: _____

CITY, STATE, ZIP _____ *RACE:* _____

PHONE: _____ *DOB:* _____ *AGE:* _____ ***M*** *or* ***F***

PHYSICIAN: _____ *SSN:* _____

PERSONAL HISTORY

- Do you drink alcoholic beverages? **Y or N** If yes, how many per day? _____
- Do you smoke? **Y or N** If yes, how many cigarettes per day? _____
  For how many years? _____
  If you have quit smoking, for how many years did you smoke? _____

MEDICAL HISTORY

- Current weight: _____
- Height at age 30: _____
- Have you ever had any of the following illnesses:

☐Alcoholism	☐Hyperparathyroidism	☐Chronic Kidney Disease	☐Osteoporosis
☐Anorexia/Bulimia	☐Hyperthyroid	☐Chronic Liver Disease	☐Paget's Disease
☐Blood Clots	☐Hypothyroid	☐Cushing's Disease	☐Rheumatoid Arthritis
☐Breast Cancer	☐Malabsorption	☐Diabetes	

- Do you have a family history of osteoporosis? **Y or N** If yes, who? _____
- Parent with a hip fracture? **Y or N**
- Please list all surgeries and give dates.

_____

_____

_____

_____

_____

(CONTINUED)

MEDICAL HISTORY(continued)

- Please list all current and/or past fractures

  Location Date Cause

_____

_____

_____

_____

_____

For Women Only

- Date of your last menstrual period:_____
- Have you ever had a hysterectomy? **Y** or **N** If yes, when? _____
- Have your ovaries been removed? **Y or N** If yes, when? _____
- Have you been through menopause? **Y or N** If yes, what age where you? _____

MEDICATION HISTORY

- Please list all medications you are currently taking including dosage and number of times taken daily. Include vitamins and over the counter medications.

_____

_____

_____

_____

_____

_____

_____

- Have you ever taken any of the following medications?

  Steroids: **Y** or **N** Osteoporosis Medications: **Y** or **N**

  *Started:*_____ *Duration:*_____ *Started:*_____ *Duration:*_____