INTERMOUNTAIN IMMC MEDICAL CLINIC™ *Our specialty is you*

REPEAT DEXA SCAN

NAME: _____ *DATE:* _____

ADDRESS: _____

CITY, STATE, ZIP _____

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

PHYSICIAN: _____

PERSONAL HISTORY

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

MEDICAL HISTORY

- Please list any new medical illnesses you have developed since you last DEXA scan.

  _____

  _____
- Please list any surgeries that you have had since you last DEXA scan.

  _____

  _____
- Please list any fractures you have had since your last DEXA scan.

  _____

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

  _____

  _____

  _____

  _____

  _____

FOR OFFICE USE ONLY

Height: _____ Weight: _____

Comments: _____

_____