FAMILY MEDICAL ASSOCIATES

DEXASCAN INSTRUCTIONS

Your physician has ordered a "Dexascan", also known as a Bone Scan. This is a screening tool to measure the density of your bones. The results are known as a "T-Score".

This test will indicate the possible risk of a future fracture,

It is a painless quick procedure which will take approximately 30 minutes.

DIRECTIONS:

1. Discontinue vitamins, calcium supplements, Evista, Actonel, Fosamax and Viactive, 36 hours prior to the appointment.

2. Clothing - No Metal on clothing, no zippers, snaps or metal tags. For women, no underwire bras. If at all possible, sweat clothes would be preferred.

Your appointment for the dexascan is scheduled for

_____@_____AM/PM

1175 DIANE CIRCLE LEWISVILLE, TEXAS 75067 TELEPHONE (972) 436-7531

BONE DENSITY QUESTIONNAIRE

Name _____ Date _____

Gender (Circle one) M or F Date of Birth _____

Ethnicity (Circle one) Black White Hispanic Asian Other

Height _____ Weight _____

Eye Color _____ Hair Color _____

Build (Circle one) Small Average Large

Referring Doctor _____

Social Security # _____

Is there any chance that you could be pregnant? Yes No

Have you had this examination before? Yes No
If so, at which medical facility _____

Are you right handed or left handed? Rt Lt

Have you had a hip replacement surgery? Yes No
If so, which hip was it performed on? Right Left Both

Have you had any surgery on your lower back? Yes No
If so, which procedure(s)? _____

_____

Did you have a known curvature of your spine? Yes No

Have you had any examinations within the past 7 days where you were injected or ingested a contrast material? If so, which exam? _____

Do you have a family history of Osteoporosis? Yes No

Do you take any medications? If so, please list _____

_____

Are you post-menopausal ? Yes No If so, at what age did menopause occur _____

Do you take calcium supplements? Yes No
If so, how often? _____

Have you had a hysterectomy? Yes No
If so, partial or complete? Year _____

Are you on hormone replacement therapy? Yes No
If so, number of years on estrogen _____

Do you have any perceived height loss? Yes No

Do you or have you taken corticosteroids? Yes No
If so, how long ago? _____

Do you exercise regularly? Yes No

Do you drink alcohol? Yes No
If so, Frequently Moderately Rarely

Do you smoke? Yes No
If so, how much? _____

Do you drink coffee? Yes No
If so, how much _____

Do you have any thyroid problems? Yes No
If so, please describe _____

Do you have any kidney problems? Yes No
If so, please describe _____

Patient Signature _____

Technologist Signature _____

Date _____