



Houston MRI

Diagnostic Radiology of Houston

DEXA SCREENING HISTORY

Phone: 713.425.8100 • Fax Orders: 713.425.8182

- 2600 N. Gessner, Ste. 150, Houston, TX 77080
- 5630 E. Sam Houston Pkwy N., Houston, TX 77015
- 1336 Pin Oak Road, Katy, TX 77494

Patient name: _____
First Name MI Last Name

Date of birth: ____/____/____ Sex: Male Female Weight: _____ Height: _____

Ethnicity: (Check One) Caucasian Black Asian Hispanic Other

Do you have any of the following:

- Cancer Yes No If yes, what type? _____
- Diabetes Yes No
- Heart Disease Yes No
- Liver Disease Yes No
- Stroke Yes No

Please list any other medical conditions not listed above:

Have you ever had surgery to your spine, hip or wrist? Yes No If yes, when and where?

Have you ever had a bone density test? Yes No If yes, when and where?

Have you ever broken a bone? Yes No If yes, which bone and how did it happen?

Have you had any procedures within the past 7 days that would have used barium, iodine or a Nuclear Medicine isotope?
 Yes No If yes, explain:

FEMALE PATIENTS ONLY

- Are you pregnant? Yes No
- Do you still have menstrual periods? Yes No
- Have you had a hysterectomy? Yes No
- Have you had both ovaries removed? Yes No
- Have you had your menopause? Yes No

 Patient's Signature or Person Authorized to
 Consent for Patient

Date: ____/____/____

Form completed by: Patient Relative Physician Other: _____