BEXARIMAGING
A WellMed Company

HISTORY AND SCREENING FORM

Name:_____ Date of Birth:_____ Age:_____

Height:_____Weight:_____ Sex: ○ Male ○ Female

Please list all allergies:

Have you had this type of examination else where? ○ Yes ○ No Location:_____

Have you ever been injected with imaging contrast / dye ? ○ Yes ○ No GFR:

Did you have an adverse / allergic reaction to the contrast / dye? ○ Yes ○ No If yes please describe:_____

DO YOU HAVE A HISTORY OF: (Check all that apply)

- Allergy to iodine, shellfish or seafood
- Arrhythmia (irregular heartbeat)
- Pulmonary Hypertension
- Heart Disease / Chest Pain
- Pheochromocytoma
- Any severe debilitating disease
- Sickle Cell Disease
- Renal Problems / Failure
- Cancer: Type _____

ARE YOU CURRENTLY: (Check all that apply)

- A dialysis patient
- Taking Glucophage or Metformin Breastfeeding or pregnant
- Taking any blood thinners (Aspirin / Coumadin)
- Taking any diuretics (water pills)
- Have the following been removed:
  - Gallbladder
  - Appendix
  - Kidney
  - Breast
  - Uterus
- Do you have ostomy bag or feeding tube
- Allergic to tape or latex

DO YOU HAVE OR HAVE YOU HAD: (Check all that apply)

- Pacemaker / Pacemaker Wires
- Heart Valve / Heart Surgery / Stents / Shunts
- Implanted Cardiac Defibrillator
- Brain Aneurysm clip / Other Brain Surgery
- Ear Surgery / Cochlear Implant / Inner Ear Prosthesis
- Vascular Access Port / Central Venous Catheter
- Metal Slivers In Eye / History of Welding / Grinding
- Shrapnel / Bullet Fragments / BBs
- Other Metal Foreign Body
- Neurostimulator / TENS / Muscular Stimulator
- Insulin Pump / Pain Pump
- Diaphragm / IUD
- Penile Implant/ Pessary / Metal Mesh
- IVC Filter
- Joint Replacement
- Metal Plates / Screws / Clips / Orthopedic Implant
- Eye Surgery / Occular Implants
- Hearing Aids / Removable Dentures
- Previous Spinal Surgery
- Tattoos / Piercing with metal jewlery
- Permanent makeup
- History of Seizures / Asthma / Diabetes
- History of liver problems / hepatitis

Surgical History: (list all previous surgeries)

1._____ Date:_____
2._____ Date:_____
3._____ Date:_____
4._____ Date:_____
5._____ Date:_____

DEXA HISTORY ONLY-HAVE YOU OR HAVE YOU BEEN

Had a previous hip or vertebrae fracture? ○ Yes ◉ No

Non-injury related fractures as an adult? ○ Yes ○ No

Did either of your parents ever have a hip fracture? ○ Yes ○ No

Do you smoke? ○ Yes ○ No

Have you taken steroids for 3 consecutive months? ○ Yes ○ No

Been diagnosed with rheumatoid arthritis? ○ Yes ○ No

Been diagnosed with secondary osteoporosis? ○ Yes ○ No

Do you drink 3 or more alcoholic drinks per day? ○ Yes ○ No

Are you being treated for Osteoporosis? ○ Yes ○ No

Perform weight bearing exercises regularly? ○ Yes ○ No

Consume dairy products regularly? ○ Yes ○ No

Drink caffeinated beverages? ○ Yes ○ No

ARE YOU CURRENTLY: (Check all that apply)

Taking the following medications:

- ☐ Actonel
- ☐ Boniva
- ☐ Evista
- ☐ Forteo
- ☐ Fosama
- ☐ Hormone Replacement
- ☐ Miacalcin
- ☐ Protelos
- ☐ Reclast
- ☐ Prolia
- ☐ Vitamin D
- ☐ Calcium

Have the following medical conditions:

- ☐ Anorexia / Bulimia
- ☐ Cancer
- ☐ Asthma / Emphysema
- ☐ Hysterectomy
- ☐ End Stage Renal Disease
- ☐ Post menopausal
- ☐ Hyperparathyroidism
- ☐ Seizure disorder
- ☐ Inflammatory Bowel Disease