

DMXI DR. ADAM G. CROUCH, INC. DBA
DIAGNOSTIC MEDICAL X-RAY AND IMAGING

Date _____ Name _____
 Date of Birth _____ Height _____ Weight _____

Answer the questions by circling the appropriate response (yes, no, unsure) to the right. If your answer is "yes", then enter additional information to the left.

GYNECOLOGIC HISTORY (WOMEN ONLY)

- | | | | |
|---|-----|----|--------|
| • Have you had hysterectomy? If yes, which year. | Yes | No | Unsure |
| • If "yes" were your ovaries removed? | Yes | No | Unsure |
| • Have you entered menopause? If yes, which year. | Yes | No | Unsure |
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MEDICATIONS

- | | | | |
|--|-----|----|--------|
| • Are you now taking hormone replacement pills or Using patches? | Yes | No | Unsure |
| • Do you take cortisone, prednisone, or other steroids For treatment of asthma, arthritis or cancer? | Yes | No | Unsure |
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LIFESTYLE

- | | | | |
|---|-----|----|--------|
| • Do you take thyroid medication? | Yes | No | Unsure |
| • Do you smoke cigarettes? Packs/day. | Yes | No | Unsure |
| • Do you drink alcoholic beverages? Drinks/day. | Yes | No | Unsure |
| • Do you exercise regularly? Amount/day? | Yes | No | Unsure |
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FRACTURES AND FALLS

- | | | | |
|--|-----|----|--------|
| • Have you ever broken any bones?
Year Site How | Yes | No | Unsure |
|--|-----|----|--------|
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HISTORY OF OSTEOPOROSIS AND BACK PAIN

- Does anyone in your immediate family have osteoporosis?
 (circle choices) Mother Father Sister(s) Brother(s)
- Do you ever have back pain?
 (circle choices) Mild or severe, dull or sharp, intermittent or constant