

Name _____ DOB _____

Email _____ Phone _____

Primary Care Provider _____

What is the primary reason for your visit today? _____

Have you ever had a DXA body composition? YES _____ NO _____

If yes, the date of the scan: _____ Location _____

Have you had unexpected recent weight gain or loss? YES _____ NO _____

If so, have you been evaluated medically? YES _____ NO _____

Have you been diagnosed with an eating disorder? YES _____ NO _____

Have you had a significant injury to one of your limbs? YES _____ NO _____

If yes, which limb? _____

Are you currently training for a competitive sport? YES _____ NO _____

If yes, what sport/event? _____

Are you on a special diet for health or training purposes? YES _____ NO _____

Have you had or planning to have bariatric surgery? YES _____ NO _____

If yes, what was/is the date of the surgery? _____

Have you been diagnosed with diabetes, high cholesterol, or heart disease? YES _____ NO _____

Do you have a family history of diabetes, high cholesterol, or heart disease? YES _____ NO _____

The risks associated with a DXA/DEXA scan are generally considered to be minimal. However, you may experience some discomfort when placed in the proper positioning for optimal scanning. DXA/DEXA scans involve exposure to radiation, therefore, you will receive a radiation dose. While higher doses of radiation are known to increase the risk of developing cancer, the doses you will receive will likely have no effects at all.

I understand that this is an X-ray of low radiation and that I am not pregnant:

Signed Name: _____ Date: _____