معهد دسمان للسكري
Dasman Diabetes Institute

Diagnostic Imaging Center

Ref. Doctor:

Contact #:

Approved By:

Patient's Label

Personal History:

Height	**cm**	**BMI**		**Age**	**Yrs**
Weight	**Kg**				

List of current medications:

	YES		YES		YES		YES
Anti-convulsants		Fosamax or Actonel		Multivitamin		Zolendronic (Zometa)	
Actonel(Risendronate)		Raloxifene hydrochloride (Evista)		Iron		**Others:**	
				Soduim Fluoride			
Calcium		Heparin		Steroids			
Calcitonin		Vitamin.D		Tamoxifen			
Evista		Ibandronate (Bovina)		Thyroid Meds			
Estrogen		Lithium					

Have you had any x-ray procedures that used contrast / Nuclear medicine within last two weeks (15) days?

EXAM	YES	NO	EXAM	YES	NO	EXAM	YES	NO	Others:
Barium Enema			CT Scan			Lung Scan			
IVU			MRI with Contrast			Cardiac Scan			
Gastro Intestinal Series			Bone Scan			Thyroid Study			

For Females ONLY:

	YES	NO		YES	NO
Are you post menopausal?	Age:		Were your ovaries removed		
Have you had a hysterectomy			Are you pregnant? **If YES, state (LMP):**		

Do you have any of the following listed conditions?

Major Risk Factors				Minor Risk Factors			
	YES		YES		YES		YES
Age > 60years		H/O Chronic bowel disease or Malabsorption		Chronic glucocorticoid Therapy		Any internal metal pins or plates implanted?	If yes, Mention:
Early menopause before age 45years		Family History of Osteoporosis		First degree relative		Any hip surgery?	If yes, Mention:
Known Osteoporosis		Radiological Osteopenia		Diabetes Mellitus		Any Broken Bone?	If yes, Mention:
Suspected Osteoporosis		Bariatric Surgery		Calcium and Vit.D deficiency		Others:	
Primary Hyperthyroidism		Cushing's Disease		Smokers			
Hypothyroidism		Hyperthyroidism		Alcohol intake			

P.O.BOX 1180, Dasman, 15462, Kuwait. Tel: 22242999 ext.7000/1 Direct Line: 22216047, www.dasmaninstitute.org

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I agree to undergo BMD examination with full knowledge of the information that has been given to me about the IDXEA before starting the procedure.

أقر بموافقتي وبمعرفتي الكاملة للمعلومات التي أعطيت لي وإني قرأت محتوى هذا النموذج وعلى فهم بما يتضمنه، وقد أتيحت لي الفرصة للسؤال حول المعلومات الواردة في هذا النموذج وفيما يخص فحص كثافة العظام.

Signature of person completing Form:
_____

توقيع المراجع الذي قام بتعبئة النموذج:
_____

Date_____/_____/_____

التاريخ_____/_____/_____

Form completed by: Patient/Relative (name Relationship to patient) _____
Nurse_____

قام بتعبئة هذا النموذج أحد أقرباء المراجع (الاسم وصلة القرابة)_____
الممرضة_____

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