DEXA PATIENT QUESTIONNAIRE

Name:_____ Date:_____

Sex: Female_____Male_____ Age:_____ Date of Birth:_____

Height:_____ Weight:_____ Menopausal Age:_____

Ethnicity (circle one): Caucasian African American Hispanic Asian Other_____

Referring Provider:_____

1.Have you had any contrast studies within the past 7 days? (circle one) YES NO

2.Have you had a previous hip or vertebral fracture? (circle one) YES NO

3.Do you have surgery/hardware in your: (circle all that apply) HIP WRIST SPINE

4.Do you have a hip replacement? (circle one) YES NO

5.Have you had any fractures in your adult life which did NOT result from significant trauma? (ex. Auto accident) (circle one) YES NO

6.Do you have a family history of hip fractures or osteoporosis? (circle one) YES NO

7.Do you smoke? (circle one) YES NO

8.Do you drink 3 or more alcoholic drinks per day? (circle one) YES NO

9.Are you being treated for osteoporosis? (circle one) YES NO

10. Have you had any chemo/ radiation treatments in the past? (circle one) YES NO

11.Do you have any of the following medical conditions? (check all that apply)

- ❑ Anorexia/ Bulimia
- ❑ Breast Cancer
- ❑ Celiac Disease
- ❑ Chronic Liver Disease
- ❑ Diabetes (Type 1, Type 2)
- ❑ Hyperparathyroidism
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ Irritable Bowel Syndrome
- ❑ Kidney Disease
- ❑ Osteopenia
- ❑ Osteoporosis
- ❑ Polymyalgia Rheumatica
- ❑ Rheumatoid Arthritis
- ❑ Vitamin D deficiency

12. Have you ever taken/currently on any of the following medications? (check all that apply)

- ❑ Actonel (i.e. risedronate)
- ❑ Boniva (i.e Ibandronate)
- ❑ Calcium
- ❑ Evenity (i.e. Romosozumab)
- ❑ Evista (i.e. raloxifene)
- ❑ Forteo or Tymlos (i.e. parathyroid hormone)
- ❑ Fosamax (i.e. alendronate)
- ❑ Hormone Replacement Therapy (i.e. Estrogen/Testosterone)
- ❑ Levothyroxine/Synthroid
- ❑ Miacalcin (i.e. calcitonin)
- ❑ Prolia (i.e. Denosumab)
- ❑ Reclast (i.e zoledronate)
- ❑ Steroids
- ❑ Vitamin D

Patient Signature_____ Technologist Initials_____

For office use only:

Comments_____

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