SMH Imaging Center℠

DEXA PATIENT HISTORY QUESTIONNAIRE

Name: _____ Today's Date: _____/ _____/ _____

Patient ID: _____ Gender: ◯ M ◯ F

Current Height: _____ ft._____ in. Date of Birth: _____/ _____/ _____

Current Weight:_____ lbs. Referring Physician: _____

Menopause Age: _____ Ethnicity: _____

1. Have you had a previous hip or vertebral fracture? ◯ Yes ◯ No
2. Have you had any fractures during your adult life which did not result from significant trauma (i.e., auto accident)? ◯ Yes ◯ No
3. Did either of your parents ever have a hip fracture? ◯ Yes ◯ No
4. Do you smoke? ◯ Yes ◯ No
5. Have you ever taken Glucocortcoids? ◯ Yes ◯ No
6. Do you have rheumatoid arthritis? ◯ Yes ◯ No
7. Do you have secondary osteoporosis? ◯ Yes ◯ No
8. Do you drink 3 or more alcoholic drinks per day? ◯ Yes ◯ No
9. Are you being treated for osteoporosis? ◯ Yes ◯ No
10. Have you ever taken any of the following medications:

◯ Actonel (i.e. risedronate) ◯ Reclast (i.e. zoledronate) ◯ HRT (i.e. estrogen/hromone therapy)
◯ Evista (i.e. raloxifene) ◯ Vitamin D ◯ Protelos (i.e. strontium ranelate)
◯ Fosamax (i.e. alendronate) ◯ Bonvia (i.e. ibandronate) ◯ Prolia (i.e. denosumab)
◯ Miacalcin (i.e. calcitonin) ◯ Forteo (i.e. parathyroid hormone) ◯ Calcium

◯ Other - please specify: _____

11. Do you have any of the following medical conditions:

◯ Anorexia or Bulimia ◯ Hyperparathyroidism ◯ Inflammatory Bowel Diseases
◯ Asthma or Emphysema ◯ Any Seizure Disorders ◯ Hysterectomy
◯ End Stage Renal Disease ◯ Cancer

◯ Other - please specify: _____

12. What was your maximum height (inches)? _____
13. Do you perform weight bearing exercise regularly? ◯ Yes ◯ No
14. Do you regularly consume dairy products? ◯ Yes ◯ No
15. Do you drink caffeinated beverages? ◯ Yes ◯ No

If female:

16. At which age did your period start? _____
17. Are you premenopausal? ◯ Yes ◯ No
18. How many full term pregnancies have you had? _____
19. Have you ever missed your period for more than 6 months in a row (not including pregnancy or menopause)? ◯ Yes ◯ No