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Dexa Scan Questionnaire

Please answer the following questions. If you are not sure how to answer a question, leave the space blank and we will assist you with the answer when you are seen at our facility. All answers will be kept in strict confidence and treated as medical record information.

Last Name: _____ First Name: _____ Date: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____Height: _____ Weight: _____

1. Race: African American ____Asian ____Caucasian ____Hispanic ____Native American ____ Other____
2. Referring physician (if any) _____
3. Have you ever had a bone density scan? Yes____ No____ Date _____ Location _____
4. Have you ever fractured any bones? Yes____ No ____ age at time of fracture __ _____
5. Is there a family history of osteoporosis? _____ relationship to you _____
6. Do you smoke? _____ If so, how many cigarettes a day? _____ How many years? _____
7. Have you smoked in the past? _____ How many years? _____
8. How many servings of calcium food items do you consume daily? _____
   (1 serving = 8oz of milk, yogurt, orange juice with calcium, 2 oz cheese or 1 1/12 cups of cottage cheese)
9. Do you take calcium supplements daily? _____ If so, how much? _____
10. Do you exercise at least three times per week? _____
11. Do you lift weights when you exercise? _____
12. How many alcoholic beverages do you consume weekly? _____
13. Have you taken any of the following medications or treatments? (Please circle all that apply)
    - A. Steroids (Prednisone, cortisone, etc.)
    - B. Thyroid medication (Levoxyl, Synthroid, Cytomel)
    - C. Anticonvulsants (for seizures)
    - D. Diuretics (lasix, bumex, edicrin, hydrochlorothiazide)
    - E. Heparin, Coumadin
    - F. Chemotherapy (Tamoxifen)
    - G. Lupron, Depo Provera
    - H. Lithium
14. Have you had any of the following conditions? (Please circle all that apply)
    - A. Hyperthyroidism or Hyperparathyroidism: _____
    - B. Biliary Cirrhosis: _____
    - C. Kidney Disease: _____
    - D. Cancer: _____
    - E. Rheumatoid Arthritis: _____
    - F. Other Arthritis: _____
    - G. Part of the stomach or intestine removed: _____Stomach stapling or bypass: _____
    - H. Intestinal or Bowel Disease: _____
    - I. Eating disorders (anorexia nervosa, bulimia, etc: _____
    - J. Spine Surgery: _____
    - K. Hip Surgery: _____

Please continue on reverse side

15. Have you had any recent contrast studies/X-rays? _____
16. Are you premenopausal or postmenopausal? _____
17. Did your menopause occur before the age of 45?_____
18. Have you had an irregular period with fewer than 6 periods per year? _____
19. Have you ever taken hormone replacement therapy? _____ If so, how many years? _____
20. Have you ever been treated for osteoporosis or weak bones? _____
    a. If so, what was the treatment? Evista, Actonel, Fosamax, Ca++, Miacalcin, Forteo
21. Have you ever had the following conditions?
    a. Ovaries removed _____
    b. Blood clots in veins of legs or lungs _____ If so, were you on hormones at the time?_____
    c. Breast cancer _____
    d. Family history of breast cancer _____
22. Do you have any general comments or questions about your health?