



Dexa Patient Questionnaire

MRN _____

Name (print) _____

Date: _____

Height _____ Weight _____

- Is there a chance that you are pregnant? Yes No
- Have you had a barium x-ray in the last 2 weeks? Yes No
- Have you had a nuclear medicine scan in the last week? Yes No
- Have you had an injection of x-ray dye in the last week? Yes No
- Have you had hyperparathyroidism level in your blood? Yes No
- Have you had a high calcium level in your blood? Yes No

If you answered yes to any of the above, speak to our receptionist right away.

1. Your age: _____ Sex: Male Female HT _____ WT _____

2. Your Ethnicity (check one):

____Caucasian (White) ____Black ____Aboriginal ____Asian ____Hispanic ____Other

3. Have you ever had a bone density test? Yes No

If YES, when and where? _____

4. Have you had a recent weight change? Yes No

If YES, tell us about it: _____

5. Your tallest height (late teens or young adult): _____

6. Have you had a change in height? Yes No

If YES, how much? _____

7. Have you ever broken a bone? Yes No

Bone broken	Simple fall	If not a simple fall, please describe the circumstances.	Age when this occurred		

8. Has a parent or sibling had a broken hip from a simple fall or bump? Yes No

9. Has the parent or sibling had any other type of broken bone from a simple fall or bump? Yes No

10. How many times have you fallen in the last year? _____

11. Have you ever had surgery of the spine, hips, legs or arms? Yes No

If YES, Describe what type of surgery you had and which side was affected

12. Are you currently receiving or have you previously received prednisone pills (cortisone)? Yes, currently__ Yes, previously__ No__

If yes, for how long?__ What is the dose?__mg or __pills each day

13. List any chronic medical conditions that you have:

14. Are you currently receiving or have previously received any of the following medications?

	Yes	No	For how long?
Medication for seizures or epilepsy			
Chemotherapy for cancer			
Medication for prostate cancer			
Medication to prevent organ transplant rejection			

15. Have you been treated with any of the following medications?

Medication	Y/N?	Currently?	If currently, how long?
Hormone replacement therapy (estrogen)			
Tamoxifen			
Raloxifene (evista)			
Testosterone			
Etidronate (Didronel/Didrocal)			
Alendronate (Fosomax)			
Risedronate (Actonel)			
Intravenous pamidronate (Aredia)			
Clodronate (Bonefos, Ostac)			
Calcitonin (Miacalcin nasal spray)			
PTH (Forteo)			
Zoledronic acid (Zometa) (Reclast)			
Sodium Fluoride (Fluotic)			
Ibandronate Sodium (Boniva)			

16. Do you take any calcium supplements (including TUMS)? Yes No

17. Do you take any vitamin D supplements (including multivitamins and halibut liver oil)? Yes No

18. Do you smoke? Yes No

FOR WOMEN ONLY

19. Are you still having menstrual periods? Yes No

20. Before menopause, have you ever missed your periods for 6 months or more, besides during pregnancy? Yes No

21. Have you had your menopause? Yes No

If YES, at what age? _____

22. Have you had a hysterectomy? Yes No

If YES, at what age? _____

Have you had both of your ovaries removed? Yes No

If YES, at what age? _____

TECHNOTES _____
