

DEXA History Questionnaire

Name: _____ Date of Birth: _____/_____/_____

Patient ID: _____ Previous DEXA: _____

Current Height (in.): _____ Weight (lbs.): _____

Referring Physician: _____ Menopause Age: _____

Have you had a previous hip or vertebral fracture: Yes No

Have you had any fractures during your adult life which
did not result from significant trauma (e.g. auto accident): Yes No

Did either of your parents ever have a hip fracture: Yes No

Do you smoke: Yes No

Have you ever taken Glucocorticoids: Yes No

Do you have rheumatoid arthritis: Yes No

Do you have secondary osteoporosis: Yes No

Do you drink 3 or more alcoholic drinks per day: Yes No

Are you being treated for osteoporosis: Yes No

Have you ever taken any of the following medications:

- | | |
|--|---|
| <input type="checkbox"/> Actonel (i.e. risedronate) | <input type="checkbox"/> Protelos (i.e. strontium ranelate) |
| <input type="checkbox"/> Boniva (i.e. ibandronate) | <input type="checkbox"/> Reclast (i.e. zolendronate) |
| <input type="checkbox"/> Forteo (i.e. parathyroid hormone) | <input type="checkbox"/> Vitamin D |
| <input type="checkbox"/> Fosamax (i.e. alendronate) | <input type="checkbox"/> Calcium |
| <input type="checkbox"/> HRT (i.e. estrogen/hormone therapy) | <input type="checkbox"/> Other – please specify: _____ |

Do you have any of the following medical conditions:

- | | |
|--|---|
| <input type="checkbox"/> Anorexia or Bulimia | <input type="checkbox"/> Inflammatory Bowel Disease |
| <input type="checkbox"/> Any Seizure Disorders | <input type="checkbox"/> Hyperparathyroidism |
| <input type="checkbox"/> Asthma or Emphysema | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> End State Renal Disease |
| <input type="checkbox"/> Other – Please specify: _____ | |

What is your maximum height (inches): _____

Do you perform weight bearing exercise regularly: Yes No

Do you regularly consume dairy products: Yes No

Do you drink caffeinated beverages: Yes No

If Female:

At what age did your period start: _____

Are you premenopausal: Yes No

How many full term pregnancies have you had: _____

Have you ever missed your period for more than
6 months in a row (not including pregnancy or menopause): Yes No