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Dexa Patient History Questionnaire

Name:		Today's Date:	
Patient ID:		Date of Birth:	
Referring Physician:		Sex:	
Ethnicity:		Height (inches):	
Menopause Age:		Weight (lbs):	

1. Have you ever had a previous Bone Density study? [ ] Yes [ ] No
   If Yes, When: _____ Where: _____
2. Have you had a previous hip or vertebral fracture? [ ] Yes [ ] No
3. Have you had any fractures during your adult life which did not result from significant trauma (e.g., auto accident)? [ ] Yes [ ] No
4. Did either of your parents ever have a hip fracture? [ ] Yes [ ] No
5. Do you smoke? [ ] Yes [ ] No
6. Have you ever taken or are currently taking steriods? [ ] Yes [ ] No
7. Do you have rheumatoid arthritis? [ ] Yes [ ] No
8. Do you have secondary osteoporosis? [ ] Yes [ ] No
9. Do you drink 3 or more alchoholic drinks per day? [ ] Yes [ ] No
10. Are you being treated for osteoporosis? [ ] Yes [ ] No

11. Have you ever taken any of the following medications:
    - ☐ Actonel (i.e. risedronate)
    - ☐ Boniva (i.e. ibandronate)
    - ☐ Evista (i.e.raloxifene)
    - ☐ Forteo (i.e. parathyroid hormones)
    - ☐ Fosamax (i.e. alendronate)
    - ☐ HRT (i.e. estrogen/hormone therapy)
    - ☐ Miacalcin (i.e. calcitoni
    - ☐ Protelos (i.e. strontium ranelate)
    - ☐ Reclast (i.e. zoledronate)
    - ☐ Prolia (i.e. denosumab)
    - ☐ Vitamin D
    - ☐ Calcium
    - ☐ Other - Please specify: _____

12. Do you have any of the following medical conditions:
    - ☐ Anorexia or Bulimia
    - ☐ Any seizure Disorders
    - ☐ Asthma or Emphysema
    - ☐ Cancer
    - ☐ End stage renal disease
    - ☐ Inflammatory bowel diseases
    - ☐ Hyperparathyroidism
    - ☐ Hysterectomy At what age? _____
    - ☐ Premenopausal
    - ☐ Other - Please specify: _____