Specialists in Prevention Diagnosis and Treatment of Adult Illness

BONE DENSITY (DXA) PATIENT QUESTIONNAIRE

PLEASE PRINT AND COMPLETE ALL PARTS

Today's Date: _______________________________

PATIENT NAME: ____

Is there a chance that you are pregnant? ☐ YES ☐ NO

Have you had a barium X-Ray in the last two weeks? ☐ YES ☐ NO

Have you had a nuclear medicine scan or injection of an X-ray dye in the last week? ☐ YES ☐ NO

Have you had hyperparathyroidism or a high calcium level in your blood? ☐ YES ☐ NO

IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, SPEAK TO OUR RECEPTIONIST IMMEDIATELY.

1. Your Age: _________ Sex (circle one): Male Female
2. Your ethnicity (check one): ___White ___Black or African American

___ Hispanic or Latino ___Native American or Amer. Indian ___Asian ___Other

Your country of birth: ______________________

3. Have you ever had a bone density test? If YES, when and where? ☐ YES ☐ NO
   ____
4. Have you had a recent weight change? If YES, please explain. ☐ YES ☐ NO
   ____
5. Your tallest height (late teens or young adult) ☐ YES ☐ NO
   ____
6. Have you ever had a broken bone? ☐ YES ☐ NO

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

7. Has a parent or sibling had a broken hip from a simple fall or bump? ☐ YES ☐ NO
8. Has a parent or sibling had any other type of broken bone from a simple fall or bump? ☐ YES ☐ NO
9. How many times have you fallen in the last year? _______________________________________
10. Have you ever had surgery of the spine, hips, legs or arms? If YES, describe what type of surgery you had and which side was affected. ☐ YES ☐ NO
    ____
11. Are you currently receiving or have you previously received prednisone pills (cortisone)? (check one) If YES currently, How long? __________ ☐ YES Currently ☐ NO
    What is your dose? _____ mg or _______ pills each day.
    If YES, previously ___ When? _________________________________
12. List any chronic medical conditions that you have:
    _____________________________________ ____
    _____________________________________ ____
    _____________________________________ ____

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

	YES	NO	How long?
Medication for seizures or epilepsy			
Chemotherapy for cancer			
Medication for prostate cancer (Men only)			
Medication to prevent organ transplant rejection			

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

Medication	Ever?	Currently?	If Current, how long?
Hormone replacement therapy (Estrogen)			
Tamoxifen, Arimadex or Femara			
Raloxifene (Evista)			
Testosterone			
Etidronate (Didronel/Didrocal)			
Alendronate (Fosamax)			
Risedronate (Actonel)			
Intravenous pamidronate (Aredia)			
Prolia (denosumab)			
Calcitonin (Miacalcin nasal spray)			
PTH (Forteo)			
Zoledronic acid (Reclast or Zometa)			
Sodium fluoride (Fluotic)			

15. Do you take any calcium supplements (including TUMS)? ☐ YES ☐ NO
    If YES, how much? Mg ___________________________
16. Do you take any Vitamin D supplements (including multivitamins? ☐ YES ☐ NO
    If YES, how much? IU ___________________________
17. Do you smoke? (or Quit date)? ☐ YES ☐ NO

FOR WOMEN ONLY

18. Are you still having menstrual periods? (LMP date _________________) ☐ YES ☐ NO
19. Before menopause, have you ever missed your periods for 6 months or more, besides during pregnancy? ☐ YES ☐ NO
20. Have you ever gone through menopause? ☐ YES ☐ NO
21. Have you had a hysterectomy? If YES, what age? __________________ ☐ YES ☐ NO
22. Have you had both of your ovaries removed? If YES, what age? ______ ☐ YES ☐ NO

I have been informed of any risks associated with this procedure.

Signature ____

Witness: ____