DEXA/BONE DENSITY QUESTIONNAIRE

Patient Name: ________________________________ **Date:** ________________

Referring Physician: __________________________ **MRN:** _______________

Reason for having Dexa/Bone Density:__________________________________

What is your race: _________________ **Weight:** ______ **Height:** _________

Are you left or right handed? ____

Do you have a history of Osteoporosis? ☐ YES ☐ NO

Do you have a curvature of the spine? ☐ YES ☐ NO

Have you had any type of fracture/broken bones? ☐ YES ☐ NO

Do you have hip, wrist, joint upper or lower mid back pain? ☐ YES ☐ NO

Have your ovaries or uterus been removed surgically? ☐ YES ☐ NO

Are you postmenopausal, if yes at what age? ☐ YES ☐ NO

Are you taking hormone therapy? ☐ YES ☐ NO

Do you take large doses of Vitamin D and/or Calcium? ☐ YES ☐ NO

Do you take anti-seizure medications? ☐ YES ☐ NO

Do you have a history of cancer, if yes are you taking chemotherapy? ☐ YES ☐ NO

Do you have a history of Renal Disease? ☐ YES ☐ NO

Do you have Rheumatoid Arthritis? ☐ YES ☐ NO

Do you have an abnormal thyroid condition? ☐ YES ☐ NO

Are you taking steroid treatment? ☐ YES ☐ NO

Do you have a history of alcohol or tobacco abuse? ☐ YES ☐ NO

Have you spent long periods of time confined to a bed? ☐ YES ☐ NO

Have you had any nuclear medicine studies of x-rays
that required contrast (dye) or barium in the last 10 days? ☐ YES ☐ NO

Are you pregnant? ☐ YES ☐ NO

Have you lost more than 2” of height since high school? ☐ YES ☐ NO

Have you had a previous Dexa/Bone Density Study? ☐ YES ☐ NO

If yes, **When**? ____________________________ **Where**? ________________________________