Patient Name ______________________________**Exam Date** __________☐**Female** ☐**Male**
DOB ________ **Ethnicity** _________________**Referring Physician** _________________________

Measured Weight_______**lbs** **Measured Height** ____**ft** ______**in** **MRN** _______________

PLEASE COMPLETE THE FOLLOWING QUESTIONNAIRE. If you answer YES to either of these first two questions, do not continue with this questionnaire. Return all forms to the receptionist, and a technologist will speak to you shortly.

☐Y ☐N Are you or do you suspect that you are pregnant?
☐Y ☐N Have you had any exam using ingested barium or x-ray dye within the past 7 days?

HISTORY

☐ Y ☐N Have you had a DXA (Bone Density) scan in the past?
When? ______________Where?___________________________
☐ Y ☐N Prior surgery to your hip(s) or spine? If yes, please explain.________________________
☐Y ☐N Do you have Hyperparathyroidism?
☐Y ☐N *Female patients only:* Have you gone through menopause? If yes, at what age?

RISK FACTORS FOR OSTEOPOROSIS

☐Y ☐N Loss of height. If yes, your height as a young adult:
☐Y ☐N Family history of osteoporosis/osteopenia
☐Y ☐N Has either biological parent had a broken hip?
☐Y ☐N Have you fractured a bone/had a stress fracture since age 40 other than hands, feet, skull? Age?______ Body part? _______________________
☐Y ☐N Do you currently smoke cigarettes?
☐Y ☐N Do you have more than 2 drinks of alcohol per day?
☐Y ☐N Have you taken daily steroids (e.g. prednisone) for 3 or more months?
☐Y ☐N Do you have a condition known to be associated with bone loss (e.g. diabetes, absorption disorder, premature menopause, crohn's disease)?
☐Y ☐N Have you been diagnosed with rheumatoid arthritis? (not osteoarthritis)
☐Y ☐N Vitamin D deficiency
☐Y ☐N Stomach bypass or banding surgery

CURRENT MEDICATIONS

☐Y ☐N Calcium and/or Vitamin D supplements
☐Y ☐N HRT (Hormone Replacement Therapy)
☐Y ☐N Anticonvulsants (Seizure medications). If yes, name of medication:
☐Y ☐N Thyroid medications. If yes, name of medication:_____________________________
☐Y ☐N DepoProvera
☐Y ☐N Are you currently taking prescription medication for osteopenia or osteoporosis. If yes, how long?

Check all medications that apply:
☐Fosamax ☐Actonel ☐Miacalcin ☐Boniva ☐Evista ☐Reclast ☐Other
☐Y ☐N Have you taken prescription medication in the past for osteopenia or osteoporosis?
If yes, how long? List medication: ____

________________________________ _______________ ___________________________
Patient Signature Date Technologist