DEXA PATIENT HISTORY QUESTIONNAIRE

Name _____ Today's Date _____

Current Height _____ Sex _____

Current Weight _____ Date of Birth _____

Menopause Age _____

1.	**Have you had a previous hip or vertebral fracture?**	**Yes**	**No**
2.	Have you had a fracture during your adult life which did not result from a significant trauma (i.e. auto accident)?	Yes	No
3.	Did either of your parents ever have a hip fracture?	Yes	No
4.	Do you smoke?	Yes	No
5.	Have you ever taken Glucocorticoids?	Yes	No
6.	Do you have rheumatoid arthritis	Yes	No
7.	Do you have secondary osteoporosis?	Yes	No
8.	Do you drink 3 or more alcoholic drinks per day?	Yes	No
9.	**Are you being treated for osteoporosis?**	**Yes**	**No**

10. Have you **<u>ever taken</u>** any of the following medications?

( ) Actonel (i.e. Risedronate)	( ) Boniva (i.e. Ibandronate)
( ) Evista (i.e. Raloxifene)	( ) Forteo (i.e. Parathyroid Hormone)
( ) Fosamax (i.e. Alendronate)	( ) Hormone Therapy (i.e. estrogen)
( ) Miacalcin (i.e. Calcitonin)	( ) Protelos (i.e. Strontium Ranelate)
( ) Reclast (i.e. Zoledronate)	( ) Prolia (i.e. Denosumab)
( ) Vitamin D	( ) Calcium

( ) Other (Please Specify) _____

11. Do you have any of the following medical conditions?

( ) Anorexia or Bulimia	( ) Any Seizure Disorder
( ) Asthma or Emphysema	( ) Cancer
( ) End Stage Renal Disease	( ) Inflammatory Bowel Disease
( ) Hyperparathyroidism	( ) Hysterectomy

( ) Other (Please Specify) _____

12.	What was your maximum height? _____		
13.	Do you perform weight bearing exercise regularly?	Yes	No
14.	Do you regularly consume dairy products?	Yes	No
15.	Do you drink caffeinated beverages?	Yes	No

If Female:

16.	At what age did your period start? _____		
17.	**Are you (circle one):**	**Premenopausal**	**Postmenopausal**
18.	How many full term pregnancies have you had? _____		
19.	Have you ever missed your period for more than 6 months in a row? (Not including Pregnancy or Menopause)	Yes	No