

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 **ever taken** any of the following medications?

- | | |
|---|---|
| <input type="checkbox"/> Actonel (i.e. Risedronate) | <input type="checkbox"/> Boniva (i.e. Ibandronate) |
| <input type="checkbox"/> Evista (i.e. Raloxifene) | <input type="checkbox"/> Forteo (i.e. Parathyroid Hormone) |
| <input type="checkbox"/> Fosamax (i.e. Alendronate) | <input type="checkbox"/> Hormone Therapy (i.e. estrogen) |
| <input type="checkbox"/> Miacalcin (i.e. Calcitonin) | <input type="checkbox"/> Protelos (i.e. Strontium Ranelate) |
| <input type="checkbox"/> Reclast (i.e. Zoledronate) | <input type="checkbox"/> Prolia (i.e. Denosumab) |
| <input type="checkbox"/> Vitamin D | <input type="checkbox"/> Calcium |
| <input type="checkbox"/> Other (Please Specify) _____ | |

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

- | | |
|---|---|
| <input type="checkbox"/> Anorexia or Bulimia | <input type="checkbox"/> Any Seizure Disorder |
| <input type="checkbox"/> Asthma or Emphysema | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> End Stage Renal Disease | <input type="checkbox"/> Inflammatory Bowel Disease |
| <input type="checkbox"/> Hyperparathyroidism | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> 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 premenopausal? | Yes | No |
| 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 |