HILLSBOROUGH RADIOLOGY CENTERS
A Partnership of Princeton Radiology & University Radiology

ROUTE 206
375 Route 206
Hillsborough, NJ 08844
908.874.7600

RAIDER BLVD
105 Raider Blvd.
Hillsborough, NJ 08844
908.359.9331

DEXA (DUAL-ENERGY X-RAY ABSORPTIOMETRY) QUESTIONNAIRE

Patient Name: _____ Date: _____

Sex: ☐ Female ☐ Male Weight: _____ Height: _____

Please select the ethnicity that **BEST** describes you:

☐ African-American ☐ Asian ☐ Caucasian ☐ Hispanic

Prior **lower** spine or hip surgery?	☐ Spine	☐ Hip	☐ None
Cement (Vertebroplasty/Kyphoplasty) in lower spine?		☐ Yes	☐ No / Unsure
Do you have HYPERPARATHYROIDISM?		☐ Yes	☐ No / Unsure
Are you left-handed or right-handed?		☐ Left	☐ Right

If you are a **male** with prostate cancer, are you taking medications to **lower** male hormones (e.g. Lupron, Zoladex, Trelstar, Viadur, Vantas, Eligard, Synarel)? ☐ Yes ☐ No or N/A

If you are a **female**, are you (select one):

☐ Pre-menopausal (I usually have regular menstrual periods)

☐ Peri-menopausal (Irregular periods, but I have had at least 1 period in the past 12 months)

☐ Post-menopausal (I have NOT had a menstrual period for more than 12 months) **or** Hysterectomy

Is there any possibility that you are pregnant? ☐ Yes ☐ No or N/A

If pregnancy is possible, when was the last day of menstrual period? _____

Do you take any of the following? (select all that apply):

Calcium supplements (including TUMS, Citracal & Caltrate)	☐ Yes	☐ No / Unsure
Vitamin D supplements (including multivitamins & cod liver oil)	☐ Yes	☐ No / Unsure
Estrogen pills/patch/gel (excluding estrogen vaginal creams)	☐ Yes	☐ No / Unsure
Tamoxifen	☐ Yes	☐ No / Unsure
Testosterone	☐ Yes	☐ No / Unsure
Raloxifene (Evista)	☐ Yes	☐ No / Unsure
Alendronate (Fosamax)	☐ Yes	☐ No / Unsure
Risendronate (Actonel/Atelvia)	☐ Yes	☐ No / Unsure
Ibandronate (Boniva)	☐ Yes	☐ No / Unsure
Calcitonin (Miacalcin nasal spray)	☐ Yes	☐ No / Unsure
Denosumab (Prolia)	☐ Yes	☐ No / Unsure
Zoledronic Acid (Zometa/Reclast)	☐ Yes	☐ No / Unsure
rhPTH 1-34 (Forteo)	☐ Yes	☐ No / Unsure
Other Osteoporosis Treatment (if yes, specify): _____	☐ Yes	☐ No / Unsure

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FRAX Questionnaire:

Do you drink 3 or more units of alcohol daily?	☐ Yes ☐ No / Unsure
Hip fracture in your father or mother?	☐ Yes ☐ No / Unsure
Currently or EVER taken ORAL/IV steroids (e.g. prednisone/cortisol) for more than 3 months? (equivalent dose of prednisone 5mg or more daily) (topical/inhaled steroids are **not** applicable) If **yes**, provide Med/Dosage:	☐ Yes ☐ No / Unsure
Have you ever suffered a **wrist/hip/pelvis/spine** fracture in your **ADULT** life which occurred **spontaneously or** arising from **low-impact trauma**? (e.g. If you suffered such a fracture after falling from a **normal standing height**, you should answer YES. If you suffered a fracture after you fell down the steps or were in a car accident, you should answer NO.)	☐ Yes ☐ No / Unsure
Do you have any reason for secondary osteoporosis? (e.g. Hyperparathyroidism, **Type I** Diabetes, Cystic Fibrosis, Osteogenesis, Imperfecta, untreated long-standing Hyperthyroidism, Hypogonadism or Premature Menopause (<45 years), chronic malnutrition/malabsorption, chronic liver/kidney disease, multiple myeloma)	☐ Yes ☐ No / Unsure
Have you been diagnosed with **RHEUMATOID** Arthritis?	☐ Yes ☐ No / Unsure
Do you currently smoke?	☐ Yes ☐ No / Unsure

Patient Signature _____ Date _____

Tech/Nurse Signature _____ Date _____

OFFICE USE ONLY:

Pregnancy Test Results: ☐ Positive ☐ Negative ☐ N/A

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