



BONE DENSITOMETRY (DEXA) QUESTIONNAIRE

Patient Name: _____ Date: _____

- 1. What is your current **WEIGHT**? _____ Pounds
- 2. What is your current **HEIGHT**? _____ Feet _____ Inches
- 3. Have you lost any **HEIGHT**? Yes No

If yes, how many **INCHES**? _____

- 4. Do you currently take any osteoporotic medication? Yes No

If yes, what is the name of the medication(s)? _____

How long have you taken the medications? _____

- 5. Do you take calcium supplements? Yes No

If yes, for how long? _____

- 6. Do you take hormone replacement? Yes No

If yes, for how long? _____

- 7. Any family history of osteoporosis? Yes No

If yes, who? _____

- 8. Do you smoke cigarettes? Yes No

- 9. Any previous: Compression spine fractures? Yes No

Hip fractures (other than from a fall)? Yes No

Wrist fractures? Yes No Which arm? _____

If yes, what? _____

- 10. Do you take steroids? Yes No

If yes, how long have you taken them? _____

DO NOT WRITE BELOW THIS LINE

Age: _____ Male Female **PEDS** Baseline Comparison MRN # _____

Fosamax Actonel Miacalcin Evista Forteo Boniva Vidura Other _____ None

Post Menopausal ___ Y ___ N Hyperparathyroidism ___ Y ___ N Hyperthyroidism ___ Y ___ N

COMMENTS: _____

Scanned by: _____

Analyzed by: _____