

Patient Questionnaire for Bone Density Testing (DXA)

Name (print): _____ Date: _____
Last First M
 Referring Physician: _____ Primary Care Physician: _____
 Date of Birth: _____ Age: _____ Social Security Number: _____
 Sex: Male Female Weight: _____ Lbs Height: _____

Is there a possibility that you are pregnant? Yes No
 Have you had x-ray using barium contrast in the last 2 weeks? Yes No
 Have you had a nuclear medicine scan or X-ray dye injection in the last week? Yes No
 Have you had hyperparathyroidism or a high calcium level in your blood? Yes No

If you answered yes to any of the above, speak to our receptionist right away.

1. Your ethnicity (please check one):
Caucasian (White) Black Asian Hispanic Other _____
2. What was your tallest height (late teens to age 25): _____
3. Have you ever had a bone density test? Yes No
 If yes, when and where _____ Results: _____
4. Have you ever had bone fracture? Yes No

Type of fracture	Due to accident or trauma (please describe)	Due to fall	At what age?

5. Has a parent or sibling had a broken hip from a fall or accident? Yes No
6. Have you ever had surgery of the spine, hips, legs or arms? Yes No
 If yes what and when? _____
7. Are you currently receiving or have you previously received prednisone (cortisone) pills?
Yes, currently ____ Yes, previously No
 If yes, for how long? _____ what is your dose? _____mg a day
8. List any chronic medical conditions that you have:

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9 Are you currently receiving or have you previously received any of the following medications?

Medication:	No	Yes	For how long?
Drugs for seizures or epilepsy			
Chemotherapy for cancer			
Medication for prostate cancer			
Medication to prevent organ transplant rejection			

10. Have you been treated with any of the following medications?

Medication	Ever?	Currently?	If current, how long?
Hormone replacement therapy (Estrogen)			
Tamoxifen			
Evista (Raloxifene)			
Testosterone			
Fosamax (Alendronate)			
(Residronate (Actonel)			
Intravenous pamidronate (Aredia)			
Miacalcine nasal spray (Calcitonin)			
Forteo (Parathyroid Hormone)			
Zometa (Zoledronic acid) Intravenous			
Reclast (Zoledronic acid) Intravenous			

11. How many servings of the following do you eat/drink per day (on average)?

	Milk (8 ounce cup)	Orange juice fortified with calcium (8 ounce cup)	Yogurt (small container or ½ cup)	Cheese
Number of servings				

12. Do you take any calcium supplements? Yes No

13. Do you take any vitamin D supplements (including multivitamin?) Yes No

14. Do you smoke? (if yes for how long _____) Yes No

For women only...

15. Are you still having menstrual periods? Yes No

16. Have you ever missed your periods for 6 months or more Yes No

17. Have you had your menopause? If yes, at what age? _____ Yes No

18. Have you had a hysterectomy and removal of both of your ovaries?
If yes, at what age? _____ Yes No