Endocrine & Diabetes Center

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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? ❐Yes ❐ No
If yes, at what age? ____________

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