

DEXA SCAN SCREENING QUESTIONNAIRE

Name: _____ Date: _____ Referring Physician: _____

Primary Physician: _____ Additional Copies to: _____

Sex: _____ DOB: _____ Age: _____ Wt: _____ Ht _____ (ft) _____ (in) Ht Loss _____

Why are you having this bone density scan? _____

Have you ever had a bone density scan? _____ Y _____ N Name of facility _____

Genetic Factors:

Family history of osteoporosis _____ Y _____ N

Have they had shortening of spine or a Dowager's Hump? _____ Y _____ N

Has your mother, grandmother, aunt(s), and/or sister(s) broken any bones including the hip, wrist, or rib? _____ Y _____ N

For Women:

Have your periods stopped? _____ Y _____ N _____ If so, when was your last period? _____

Has your uterus been removed? _____ Y _____ N Have your ovaries been removed? _____ Y _____ N

Have you had breast cancer, ovarian cancer, or uterine cancer? _____ Y _____ N

For Men:

Have you ever been treated for prostate cancer? _____ Y _____ N Do you take Lupron injections? _____ Y _____ N

Have you ever been treated for testicular hypo function? _____ Y _____ N

FACTORS THAT CAN PROTECT AGAINST OSTEOPOROSIS:

How many servings of dairy products do you have daily? (Milk,cheese,yogurt,etc.) _____ 0, 1, 2, 3, 4, 5+ (circle one)

Do you have lactose or milk intolerance? _____ Y _____ N Do you exercise regularly? _____ Y _____ N

What type of exercise?(i.e.walking,running,etc.) _____

MEDICATIONS

Calcium Supplements(including TUMS)	Taking now or Previously Taken? Circle: Y N	Amount:	If stopped, when?
Multiple Vitamins	Taking now or Previously Taken? Circle: Y N	Amount:	If stopped, when?
Estrogen	Taking now or Previously Taken? Circle: Y N	Amount:	If stopped, when?
Progesterone	Taking now or Previously Taken? Circle: Y N	Amount:	If stopped, when?
Fosamax	Taking now or Previously Taken? Circle: Y N	Amount:	If stopped, when?

Actonel	Taking now or Previously Taken? Circle: Y N	Amount:	If stopped, when?
Forteo(injections)	Taking now or Previously Taken? Circle: Y N	Amount:	If stopped, when?
Miacalcin nasal spray	Taking now or Previously Taken? Circle: Y N	Amount:	If stopped, when?
Evista	Taking now or Previously Taken? Circle: Y N	Amount:	If stopped, when?
Boniva (oral)	Taking now or Previously Taken? Circle: Y N	Amount:	If stopped, when?
Ibandronate(intravns)	Taking now or Previously Taken? Circle: Y N	Amount:	If stopped, when?

List all other prescription medications and over the counter currently taking_____

FACTORS THAT INCREASE THE RISK OF OSTEOPOROSIS:

Do you now or have you ever smoked?____Y____N How long?_____? How much?_____

Date Quit?_____ Do you drink alcohol?__Y____N How much?_____

Have you taken long-term steroid medications such as prednisone, dexamethasone, or cortisone for more than three months?____Y____N

Do you take seizure medications?_____Y____N If so, which medication(s)?_____

Have you had any major problems with:

Kidneys:_Y____N Liver disease____Y____N Thyroid disease_____Y____N

Rheumatoid arthritis____Y____N Parathyroid____Y____N Paget's disease of bone?__Y____N

Digestive problems? (i.e. Sprue, Crohn's, ulcerative colitis, IBS, ulcers, GERD.)_____Y____N

Have you had any major problems with cancer?_____Y____N Did you have radiation or chemo?_____Y____N

Have you ever had an eating disorder such as anorexia or bulimia?_____Y____N

Have you ever broken any bones?_____Y____N Which bones?_____

Have you had surgery on either your hips or your spine?_____Y____N Any major health problems?____Y____N

Explain:_____

Patient Signature_____

Date:_____

Technologist's Comments:_____

