



DEXA/BONE DENSITOMETRY PATIENT QUESTIONNAIRE

NAME: _____	MENOPAUSE AGE: _____ (if applicable)
ETHNICITY: _____	SEX: F M
HEIGHT: _____ in.	WEIGHT: _____ lbs.

- 1. Have you had a Nuclear Medicine or any x-ray exam requiring the use of barium in the past 7 days? **YES NO**
- 2. Are you **RIGHT** or **LEFT** handed? **RIGHT LEFT**
- 3. Do you have a history of anorexia/low body weight? **YES NO**
- 4. Have you had loss of height? **YES NO**
- 5. Do you have a history of excessive back pain? **YES NO**
- 6. Have you had a previous hip or vertebral fracture? **YES NO**
- 7. Have you had any fractures during your adult life which did not result from significant trauma? **YES NO**
- 8. Did either of your parents ever have a hip fracture? **YES NO**
- 9. Do you smoke? **YES NO**
- 10. Have you ever taken Glucocorticoids and/or other steroids? **YES NO**
- 11. Do you have rheumatoid arthritis? **YES NO**
- 12. Do you have secondary osteoporosis (osteoporosis due to medications/disease processes or disorders)? **YES NO**
- 13. Do you drink 3 or more alcoholic drinks per day? **YES NO**
- 14. Are you being treated for osteoporosis? **YES NO**

If yes, what medication? _____

15. Have you had any of the following back or hip conditions? Check all that apply.

- Back Surgery
- Hip Surgery
- Curvature of the spine
- Broken vertebrae
- Other – Please specify: _____

16. Have you been diagnosed with any of the following conditions? Check all that apply.

- Hyperparathyroidism
- Cushing Syndrome
- Turner’s Syndrome
- XO Syndrome
- Ovarian failure after surgery or radiation
- Premature menopause (before 40)
- Osteoporosis
- Gonadal Dysgenesis
- Other– Please specify: _____

- 17. Do you regularly consume dairy products? **YES NO**
- 18. Do you take calcium supplementation? **YES NO**
If yes, when was your last dose? _____
- 19. Do you drink caffeinated beverages? **YES NO**

Female patients only:

- 20. At what age did your periods start? _____
- 21. Are you **PREMENOPAUSAL** (menstrual cycles have NOT stopped)? **YES NO**
- 22. How many full term pregnancies have you had? _____

Signature: _____ **Date:** _____

Thank you for choosing AAR