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