

Patient History Questionnaire

Bone Density Modality (DEXA)



Name: _____ Today's Date _____

Patient ID: _____ Date of Birth _____

Current height: _____ Referring Physician _____

Current weight: _____ Male Female Ethnicity: _____

- Yes No Have you had a previous hip or vertebral fracture?
- Yes No Have you had any fractures during your adult life that did not result from trauma? (i.e. auto accident)
- Yes No Did either of your parents ever have a hip fracture?
- Yes No Do you smoke?
- Yes No Have you ever taken Glucocorticoids (steroid hormones)
- Yes No Do you have rheumatoid arthritis?
- Yes No Do you have secondary osteoporosis?
- Yes No Do you drink 3 or more alcoholic drinks per day?
- Yes No Are you being treated for osteoporosis?

Have you ever taken any of the following medications?

- Actonel (i.e. risedronate)
- Evista (i.e. raloxifene)
- Fosamax (i.e. alendronate)
- Miacalcin (i.e. calcitonin)
- Reclast (i.e. zoledronate)
- Vitamin D
- Boniva (i.e. ibandronate)
- Forteo (i.e. parathyroid hormone)
- HRT (i.e. estrogen/hormone therapy)
- Protelos (i.e. strontium ranelate)
- Prolia (i.e. denosumab)
- Calcium

Other - please specify _____

Do you have any of the following medical conditions?

- Anorexia or Bulimia
- Asthma or Emphysema
- End stage renal disease
- Hyperparathyroidism
- Any seizure disorders
- Cancer
- Inflammatory bowel diseases
- Hysterectomy

Other - please specify _____

What was your maximum height? _____

- Do you perform weight bearing exercise regularly? Yes No
- Do you regularly consume dairy products? Yes No
- Do you drink caffeinated beverages? Yes No

If female:

At what age did your period start: _____ Home many full term pregnancies have you had? _____

Are you premenopausal? _____ Have you ever missed your period for more than 6 months in a row (not including pregnancy or menopause)? _____

Menopause age? _____