DEXA BONE DENSITY SCREENING
PATIENT QUESTIONNAIRE

Please Answer ALL Questions

_____ _____ _____
(Your Name) Date of Birth (Today's Date)

	YES	NO
Is there any chance you may be pregnant?	☐	☐
Do you have any metal in your spine and/or hips?	☐	☐
Have you ever broken (or fractured) a bone? If yes, which bone? _____ Were you a ☐ Child (20 or younger) or ☐ adult?	☐	☐
Do you consume beverages with alcohol? If yes, how many drinks per day? _____	☐	☐
Do you take any medication to control seizures?	☐	☐
Do you take any medication to control epilepsy?	☐	☐
Do you take any medication to control convulsions?	☐	☐
If you have menstrual cycles (periods), do they occur at regular intervals?	☐	☐
Have you had a hysterectomy? Partial hysterectomy? (uterus only) Complete hysterectomy?	☐	☐
If you have gone through menopause (change of life), was it at 45 years old or younger?	☐	☐
Do you take steroids for chronic arthritis and/or chronic asthma (bronchitis)?	☐	☐
Do you have any kind of intestinal problem such as Crohn's Disease or Ulcerative Colitis?	☐	☐
Do you smoke cigarettes?	☐	☐
Have you ever smoked cigarettes?	☐	☐
Do you have a family history of osteoporosis (mother, grandmother, aunt or sister)?	☐	☐
Have you lost height (become any shorter)?	☐	☐
Do you take medication for thyroid problems? If yes, what medication do you take? _____		

_____
(Your Name)

Do you eat/drink at least 3 servings of calcium rich food/drink ***every*** day?	☐	☐
Has a physician ever told you that **you** have osteopenia or osteoporosis (significant bone loss)?	☐	☐
Do you take medication for osteopenia?	☐	☐
Do you take medication for osteoporosis?	☐	☐
Do you have times when you fall for no specific reason?	☐	☐
Have you had renal (kidney) failure?	☐	☐
If so, are you on dialysis?	☐	☐
Do you take birth control pills or any type of estrogen?	☐	☐
Are you one hormone replacement therapy?	☐	☐
Do you take calcium pills?	☐	☐
Do you take vitamin D or a multi-vitamin?	☐	☐