

First name:	Last name:	DOB:		_
Prior DXA scan location and date:				
Patient's tallest height:	_ (inches)			
In there a change that you are progre	nt?		V 0 0	No
Is there a chance that you are pregna			Yes	No
Have you had a barium x-ray in the la	st 2 weeks?	`	Yes	No
Have you had a nuclear medicine sca	n or injection of an x-ray dye in the	last week?	Yes	No
Have you taken calcium or a multi-vita	amin today?	•	Yes	No
Have you had a hip replacement?  If so, what side?	Right Left Both	•	Yes	No
Have you ever fractured a spine, hip, trauma?	wrist or shoulder bone due to a sim	ple fall or with no	Yes	No
As an adult, have you ever fractured, skull) with minor trauma?	cracked or broken a bone (excludin	g hands, feet, neck and	Yes	No
Did your mother or father break or frac	cture a hip at any age?		Yes	No
Do you currently smoke cigarettes?			Yes	No
Have you ever smoked cigarettes?			Yes	No
On average do you drink three or mor	e alcoholic beverages per day?		Yes	No
Have you taken 450mg or more of pre equivalent) in your lifetime?	ednisone (5mg/daily for 3 or more m	onths lifetime or	Yes	No
Has a doctor told you that you have rh	neumatoid disease or positive rheur	natoid test?	Yes	No
Have you ever taken methotrexate?			Yes	No
Have you ever been diagnosed with a	ny of the following conditions:			
Insulin dependent diabetes (Type	1)		Yes	No
Osteogenesis imperfect as an adul	It		Yes	No
Long-standing untreated overactive	e thyroid		Yes	No
Low testosterone or Hypogonadisn	n		Yes	No
Premature menopause (before age	e 45)		Yes	No
Chronic malnutrition			Yes	No
Malabsorption			Yes	No
Chronic liver disease			Yes	No
If you answered yes to any of the con-	ditions above, please elaborate:			

Have you had your menopause (no periods for 12 months or more)?  If you had your menopause, what age was your last period?	Yes	No
Have your ovaries been removed?  If you had your ovaries removed, at what age?	Yes	No
Have you ever been diagnosed with hyperparathyroidism?	Yes	No
Have you ever taken Dilantin (phenytoin), Tegretol (carbamazepine), Depakote (valproic acid) or phenobarbital?	Yes	No
Have you ever taken Arimidex (anastrozole), Femara (letrozole), Lupron (leuprolide), or Aromasin (exemestane)?	Yes	No
Do you take calcium supplements (including TUMS)?	Yes	No
Do you take vitamin D supplements?	Yes	No
Have you taken any of the following medications for three or more months over the last		
two years: Fosamax (alendronate)	Yes	No
Actonel (risedronate)	Yes	No
Boniva (ibandronate)	Yes	No
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ReClast (zoledronate)	Yes	No
Have you taken any of the following medications for three or more months over the last one year:		
Estrogen pills or patches, hormone replacement pills or patches	Yes	No
Evista (raloxifene)	Yes	No
Miacalcin nasal spray	Yes	No
Forteo (teriparatide) by injection (shots)	Yes	No
Prolia (denosumab)	Yes	No
If you answered yes to any of the conditions above, please elaborate:		
Questionnaire reviewed by:Date of Service	):	