PRE-DEXA SCAN PATIENT QUESTIONAIRE

Date:_____

First Name: _____ M.I._____ Last Name:_____

SS#_____/_____/_____ Sex: M / F Age:_____ D.O.B._____

Referring Doctor Last Name:_____ First Name:_____

Height:_____ Weight:_____ Height Loss? Y N Inches:_____

Ethnicity: White Black Hispanic Asian

Adult/Child Fractures? Y N _____ Hip Replacement? Y N Spinal Surgery? Y N

Prior Scans? Y N Arthritis? Y N _____ Thyroid Problems? Y N _____

Suffer From Pain? Y N_____ Other Diseases? _____

Family History of Osteoporosis? Y N If So Who?_____

Alcohol Intake? _____ Smoke? Y N Years_____Quit?_____

Do You Take ?

Evista? Y N _____mg Duration:_____

Fosamax? Y N _____mg Duration:_____

Actonel? Y N _____mg Duration:_____

Boniva? Y N _____mg Duration:_____

Reclast? Y N _____mg Duration:_____

Forteo? Y N _____mg Duration:_____

Hormone Replacement Therapy? Y N_____mg Duration:_____

Calcium? Y N _____mg Duration:_____

Vitamins? Y N _____mg

Exercise? Y N Type_____ How Often? _____