Banner Health®

DEXA/BONE DENSITY PATIENT QUESTIONNAIRE

HEIGHT: _____ WEIGHT: _____ REFERRING PHYSICIAN _____
GENDER: _____
ETHNICITY: ❑ ASIAN ❑ HISPANIC ❑ CAUCASIAN ❑ AFRO-AMERICAN ❑ NATIVE AMERICAN ❑ OTHER

HAVE YOU BROKEN ANY BONES AFTER AGE 50: ❑ YES ❑ NO IF YES: LIST WHICH BONES: _____
DO YOU HAVE HISTORY OF THE FOLLOWING (PLEASE CHECK)

❑ RHEUMATOID ARTHRITIS	❑ ETOH +3	❑ BACK PAIN ❑ HIP PAIN ❑ JAW PAIN
❑ CANCER Type: _____	❑ RADIATION / CHEMOTHERAPY	❑ DIABETES ❑ CYSTIC FIBROSIS
❑ HEIGHT LOSS	❑ HEPATITIS C	❑ MALABSORPTION/SMALL BOWEL DISEASE
❑ HYPERPARATHYROIDISM	❑ HYPERTHYROIDISM	❑ HYPOTHYROIDISM
❑ CALCIUM DISORDER	❑ HYSTERECTOMY	❑ OOPHORECTOMY (REMOVAL OF OVARIES)
❑ KIDNEY STONES	❑ KIDNEY DISEASE	❑ LIVER DISEASE
❑ HX OF PARENT HAVING A FRACTURE HIP	❑ LUPUS	❑ STEROID USE (Glucocorticoids or Prednisone)
❑ FAMILY HISTORY OF OSTEOPOROSIS	❑ OSTEOPENIA (LOW BONE DENSITY)	❑ OSTEOPOROSIS

PLEASE LIST ANY OTHER HEALTH PROBLEMS: _____

WHAT IS THE REASON FOR YOUR DEXA SCAN TODAY? _____
ARE YOU PRE-MENOPAUSAL? ❑ YES ❑ NO DATE OF LAST MENSTRUAL PERIOD _____
ARE YOU POST-MENOPAUSAL? ❑ YES ❑ NO AGE AT MENOPAUSE _____

ARE YOU TAKING NATURAL AND/OR PRESCRIPTION HORMONES? ❑ YES ❑ NO IF YES, HOW LONG? _____

ARE YOU TAKING BONE REPLACEMENT THERAPY: ❑ YES ❑ NO IF YES, HOW LONG? _____

ARE YOU TAKING CALCIUM? ❑ YES ❑ NO LAST DOSE TAKEN: _____

ARE YOU A SMOKER? ❑ YES ❑ NO

LIST ANY OTHER MEDICATIONS: _____
IN THE PAST TWO WEEKS, HAVE YOU HAD ANY EXAMS THAT INVOLVED THE USE OF DYE OR BARIUM? ❑ YES ❑ NO

DO YOU HAVE ANY METAL IN YOUR HIP AND/OR SPINE? ❑ YES ❑ NO
❑ RIGHT HIP ❑ LEFT HIP ❑ SPINE
HAVE YOU HAD ANY ABDOMINAL SURGERIES? ❑ YES ❑ NO
LIST: _____
HAVE YOU HAD A BONE DENSITY SCAN BEFORE?
WHEN _____ WHERE _____

PATIENT SIGNATURE _____ DATE _____

TECHNOLOGIST _____