



OCH CENTER FOR BREAST HEALTH AND IMAGING
DEXA SCAN QUESTIONNAIRE

Date: _____ Referring Dr: _____

Name: _____ Date of Birth: _____

Sex: Male or Female Height (in): _____ Weight (lb): _____

Menopause Age: _____ Ethnicity: _____

1. Have you had a previous hip or vertebral fracture? ___ Yes ___ No
2. Have you had any fractures during your adult life which did not result from significant trauma (e.g. auto accident)? ___ Yes ___ No
3. Did either of your parents ever have a hip fracture? ___ Yes ___ No
4. Do you smoke? ___ Yes ___ No
5. Have you ever taken Glucocorticoids? ___ Yes ___ No
6. Do you have rheumatoid arthritis? ___ Yes ___ No
7. Do you have secondary osteoporosis? ___ Yes ___ No
8. Do you drink 3 or more alcoholic drinks per day? ___ Yes ___ No
9. Are you being treated for osteoporosis? ___ Yes ___ No
10. Have you ever taken any of the following medications?
 - ___ Actonel (i.e. risedronate) ___ Boniva (i.e. ibandronate)
 - ___ Evista (i.e. raloxifene) ___ Forteo (i.e. parathyroid hormone)
 - ___ Fosamax (i.e. alendronate) ___ HRT (i.e. estrogen/hormone therapy)
 - ___ Miacalcin (i.e. calcitonin) ___ Protelos (i.e. strontium ranelate)
 - ___ Reclast (i.e. zoledronate) ___ Prolia (i.e. denosumab)
 - ___ Vitamin D ___ Calcium
 - ___ Other- please specify _____
11. Do you have any of the following medical conditions:
 - ___ Anorexia or Bulimia ___ Seizure Disorders
 - ___ Asthma or Emphysema ___ Cancer
 - ___ End stage renal disease ___ Inflammatory bowel diseases
 - ___ Hyperparathyroidism ___ Hysterectomy
 - ___ Other: Please specify _____
12. What was your maximum height (inches)? _____
13. Do you perform weight bearing exercise regularly? ___ Yes ___ No
14. Do you regularly consume dairy products? ___ Yes ___ No
15. Do you drink caffeinated beverages? ___ Yes ___ No

If female:

16. At what age did your period start? _____
17. Are you premenopausal? ___ Yes ___ No
18. How many full term pregnancies have you had? _____
19. Have you ever missed your period for more than 6 months in a row (not including pregnancy or menopause)? ___ Yes ___ No



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REVISION HISTORY

Author	Revision Date	Page #	Summary of Changes
Tawana Gipson	9/20/2016	1	Header and Footer added