DXA Patient Screening Questionnaire

WELCOME! Please answer each question by checking the correct box and filling in the blanks where needed so we can provide the best possible care. After the questionnaire is completed, the technologist will review all of the responses and provide you the opportunity to ask questions before your DXA exam.

Gender	Female ☐	Male ☐	Height	Weight	
Ethnicity	White ☐	Black ☐	Asian ☐	Hispanic ☐	Other ☐

YES	NO	
☐	☐	Have you ever had a fracture over the age of 40 that occurred with little or no trauma (such as a fall from standing, walking, or sitting)? If YES, please indicate the location of the fracture (i.e., hip, spine, upper arm) and the date.
☐	☐	Did your mother or father ever fracture a hip?
☐	☐	Do you currently smoke?
☐	☐	Regarding alcohol consumption, do you drink more than 3 servings per day?
☐	☐	Do you have hyper**para**thyroidism?
☐	☐	Have you been **diagnosed** with rheumatoid arthritis (not osteoarthritis/degenerative arthritis)?
☐	☐	Do you have Type I diabetes (insulin dependent)?
☐	☐	Do you have **untreated** longstanding hyperthyroidism?
☐	☐	Do you have chronic malnutrition (such as anorexia nervosa)?
☐	☐	Do you have any malabsorption disorder (perhaps due to gastric bypass, Chrohn's, or celiac disease)?
☐	☐	Do you have chronic liver disease (such as cirrhosis or chronic hepatitis)?
☐	☐	For female patients: Have you had your ovaries removed? If YES, at what age?
☐	☐	For female patients: Are you postmenopausal? If YES, what was your age at menopause?
☐	☐	Have you ever taken hormone replacement therapy? If YES, are you currently on/when did you stop therapy?
☐	☐	Have you ever had cancer? If YES, please indicate the type of cancer.
☐	☐	Have you ever had chemotherapy?
☐	☐	Have you ever had radiation treatment? If YES, please provide the part of your body treated and the date.
☐	☐	Have you ever taken any of the following medications? If YES, please circle which one(s). Anastrazole Arimidex Aromasin Femara Letrozole
☐	☐	Have you ever taken any of the following medications ***related to bone health***? If YES, please circle which one(s). Actonel Alendronate Boniva Calcitonin Evista Fareston Forteo Fosamax Ibandronate Miacalcin Prolia Reclast Risedronate Tamoxifen Teriparatide X-Geva Zolendronic acid OTHER If OTHER, please specify: If you stopped taking the medication(s), when did you stop?
☐	☐	Are you taking the following supplements? Calcium ☐ Vitamin D ☐ Multivitamin ☐
☐	☐	Have you taken corticosteroids (i.e., cortisone, hydrocortisone, prednisone or Depo-Medrol) longer than **3 months**?
☐	☐	Have you had surgery on your back or hips?
☐	☐	Have you had a bone density exam (DXA) before? If yes, please provide the name(s) of the facility where performed and the date(s).

Technologist Comments

KMC TMC BC

NHI M NHI P Other

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Name / MR # / Label