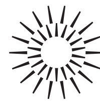
Carol Milgard
Breast Center



DEXA Patient History Questionnaire

Name: ______________________ Date of Birth: ____________

Current Height (in): ________ Weight (lb): ________ Gender: ❑ F ❑ M ❑ Other

Menopause Age: ________ Ethnicity: ______________________

Referring Physician: ______________________

1. Have you had any fractures as an adult not caused by an injury or fall? ❑ Yes ❑ No
2. Did either of your parents ever have a hip fracture? ❑ Yes ❑ No
3. Do you smoke currently? ❑ Yes ❑ No
4. Have you ever taken Prednisone/steroids? *(more than 2 months. What age: ____)* ❑ Yes ❑ No
5. Do you have rheumatoid arthritis? ❑ Yes ❑ No
6. Do you have secondary osteoporosis (caused by medical treatment)? ❑ Yes ❑ No
7. Do you drink 3 or more alcoholic beverages per day currently? ❑ Yes ❑ No
8. Are you being treated for osteoporosis? ❑ Yes ❑ No
9. Ever had any fractures or surgery to the spine or hips? ❑ Yes ❑ No

11. **Please indicate with a check mark if you have ever taken any of the following medications:**

❑ Actonel (i.e. risedronate)
❑ Evista (i.e. raloxifene)
❑ Fosamax (i.e. alendronate)
❑ Miacalcin (i.e. calcitonin)
❑ Reclast (i.e. zoledronate)
❑ Calcitonin Spray
❑ Boniva (i.e. ibandronate)
❑ Letrozole
❑ Fareston
❑ HRT (i.e. estrogen/hormone therapy)
❑ Forteo
❑ Prolia
❑ Aromasin
❑ Tamoxifen
❑ Vitamin D
❑ Calcium
❑ Femara
❑ Arimidex

12. **Do you now or have you ever had any of the following medical conditions?**

❑ Anorexia or bulimia
❑ Asthma or emphysema
❑ End stage renal disease
❑ Hyperparathyroidism *(not hyperthyroidism)*
❑ Any seizure disorders
❑ Inflammatory bowel diseases
❑ Cancer (what kind) ______________________
❑ Other ______________________
❑ **Osteopenia**
❑ **Osteoporosis**

13. What was your maximum height (inches): ______________
14. Do you perform weight bearing exercise regularly? ❑ Yes ❑ No
15. Do you regularly consume dairy products? ❑ Yes ❑ No
16. Do you drink caffeinated beverages? ❑ Yes ❑ No

Females only

17. At what age did your period start: ________
18. **Are you premenopausal?** ❑ Yes ❑ No
19. **Are you postmenopausal?** ❑ Yes ❑ No
20. **Hysterectomy?** ❑ Yes ❑ No

Ovaries removed? ❑ Yes ❑ No

21. Number of births: ____________
22. Have you ever missed a period for more than 6 months in a row? ❑ Yes ❑ No
(other than for pregnancy or menopause)

Patient Signature ______________________ **Date** ____________