DEXA SCREENING FORM

Name: DOB: Age: Weight: Height: Sex:

Ethnicity: Menopause Age: MRN:

☐ Yes ☐No Have you had a previous hip or vertebral fracture?
☐ Yes ☐No Have you had any fractures 40+ years old from significant trauma? (i.e. car accident)
☐ Yes ☐No Did either of your parents ever have a hip fracture?
☐ Yes ☐No Do you smoke?
☐ Yes ☐No Have you ever taken Glucocorticoids?
☐ Yes ☐No Do you have rheumatoid arthritis?
☐ Yes ☐No Do you have secondary osteoporosis?
☐ Yes ☐No Do you drink 3 or more alcoholic drinks per day?
☐ Yes ☐No Are you being treated for osteoporosis?

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 _____

Do you have any of the following medical conditions?

☐Anorexia or Bulimia
☐Any Seizure Disorder
☐Asthma or Emphysema
☐Cancer
☐End stage renal disease
☐Inflammatory bowel disease
☐Hyperparathyroidism
☐Hysterectomy
☐Other- Please specify _____

What is you maximum height (inches)? _____

☐ Yes ☐No Do you perform weight bearing exercise regularly?
☐ Yes ☐No Do you regularly consume dairy products?
☐ Yes ☐No Do you drink caffeinated beverages?

If female:

At what age did your period start? _____

☐ Yes ☐No Are you premenopausal?

How many full-term pregnancies have you had? _____

☐ Yes ☐No Have you ever missed your period for more than 6 months in a row (not including pregnancy or menopause)?