Confirmed patients name and DOB ◯_____

RHODE ISLAND **MEDICAL IMAGING**

DEXA Patient History Questionnaire

Name: _____ DATE: _____

Patient ID: _____ SEX: ◯ F ◯ M

Current Height: _____inches Date of Birth:_____

Weight: _____lbs. Ethnicity: _____

Menopause age: _____ Referring Physician: _____

1. Have you had a previous hip, vertebral, sacrum or coccyx fracture? ◯ Yes ◯ No
2. Have you had any fractures during your adult life which did not result from significant trauma like and 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 non-topical steroids (oral or inhaled), including 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 beverages per day? ◯ Yes ◯ No
9. Are you being treated for osteoporosis? ◯ Yes ◯ No
10. Have you ever taken, or are currently taking any of the following medications?
    - ◯ Actonel (risedronate)
    - ◯ Evista (raloxifene)
    - ◯ Fosamax (alendronate)
    - ◯ Miacalcin (calcitonin)
    - ◯ Reclast (zoledronate)
    - ◯ Vitamin D
    - ◯ Other - please specify: _____
    - ◯ Boniva (ibandronate)
    - ◯ Forteo (parathyroid hormone)
    - ◯ ERT/HRT (estrogen/hormone therapy)
    - ◯ Protelos (strontium ranelate)
    - ◯ Prolia (denosumab)
    - ◯ Calcium
11. Do you have any of the following medical conditions?:
    - ◯ Anorexia or Bulimia
    - ◯ Asthma or Emphysema
    - ◯ Cushing syndrome
    - ◯ Hyperparathyroidism
    - ◯ Inflammatory bowel diseases
    - ◯ Any Seizure Disorders
    - ◯ Cancer
    - ◯ End stage renal disease
    - ◯ Hysterectomy/Ovaries removed
    - ◯ Premature menopause/ovarian failure
    - ◯ Atrophic vaginitis
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. At what age did your period end?_____
18. Are you menopausal? ◯ PRE ◯ PERI ◯ POST
19. How many full term pregnancies have you had?_____

7/21/17 sms