

**DEXA - BONE DENSITOMETRY
PATIENT QUESTIONNAIRE**

DATE: _____

NAME: _____ AGE: _____

HEIGHT: _____ FT.: _____ INCHES: _____ WEIGHT: _____ LBS

CHECK ONE: PREMENOPAUSAL _____
 POSTMENOPAUSAL _____
 AGE AT MENOPAUSE _____

HAVE YOU EVER HAD A HYSTERECTOMY? _____ YES _____ NO
IF YES, AT WHAT AGE? _____

HAVE YOU EVER HAD THIS TEST DONE? _____ YES _____ NO
DATE: _____

DID YOU HAVE ANY OF THE FOLLOWING TESTS IN THE PAST WEEK:

NUCLEAR MEDICINE _____ YES _____ NO
 BARIUM _____ YES _____ NO

ARE YOU PRESENTLY ON ANY MEDICATIONS? IF SO, WHAT ARE THEY?

ANY HISTORY OF FRACTURES? _____ YES _____ NO
IF YES, WHERE AND WHEN? _____

ANY HIP, SPINE, WRIST PROSTHETICS? _____

WHICH IS YOUR DOMINANT SIDE (RIGHT or LEFT HANDED?) _____

REFERRING PHYSICIAN _____

ARE YOU ON HORMONE REPLACEMENT THERAPY? _____ YES _____ NO
IF YES, WHAT KIND? _____ FOR HOW LONG? _____

HAVE YOU HAD ANY SURGERIES IN THE PAST? _____

SIGNATURE: _____