Oregon Medical Group Imaging Department
920 Country Club Rd. Eugene, OR 97401
Phone 541-242-4162 Fax 541-345-2358

DEXA (Bone Densitometry) Questionnaire

Name: _____ Date of Birth: _____
Age: _____ Ethnicity **(Circle One):** Asian Black Caucasian Hispanic Other
Primary Care Physician: _____ Height: ____' ____"
Additional Reports to: _____ Weight: _____ lbs.

Have you ever had a DEXA scan before? Y / N If so, When? _____ and, Where? _____
Do you have a family history of osteoporosis? Y / N Who? _____
Did your parent(s) ever fracture a hip? Y / N
Have you fractured or broken any bones during your adult life? Y / N
What bone(s) and When? _____

Do you currently smoke? Y / N How long? _____ Have you smoked in the past? Y / N
Do you drink 3 or more alcoholic drinks per day? Y / N
Do you take Glucocorticoids? Y / N (Circle which type): Prednisone Dexamethasone Hydrocortisone
Have you been diagnosed with Rheumatoid Arthritis (RA)? Y / N

On average, how many times per week do you exercise? _____ times per week.
What kind of exercise do you do? _____

Do YOU take: Calcium supplements? Y / N How much? _____ mg / day
Multi-vitamin? Y / N
Vitamin D? Y / N How much? _____ iu How often? Daily Weekly Monthly
Osteoporosis Medication (Circle which one): Actonel Boniva Evista Forteo
Fosamax Miacalcin Reclast
How long have you taken this medication? _____

Have you had surgery on your lower back? Y / N or your hip(s)? Y / N When? _____
Do you have metal implants / hardware from your back or hip surgery? Y / N

Please circle any of the following conditions you have had or have, and any medications that you are currently taking or have taken in the past:

Lactose Intolerant	Anticonvulsants (Dilantin)	Lupus	Tamoxifen	Arimidex	Femara
Crohn's Disease	Steroids (Prednisone)	Heparin	Diabetes: Type-1(juvenile) **<or>** Type-2(adult)		
Kidney Disease	Breast Cancer	Testosterone	Scoliosis	Prostate Cancer	
Synthroid/Thyroxin	Transplant, Organ: _____				

Remaining Questions for Women Only:

Are you pregnant? Y / N What age were you when you started **menopause**? _____ years old.
Have you had your ovaries removed? Y / N
Do you currently take hormones? Y / N (Circle one) Estrogen Progesterone How long? _____
Have you taken hormones in the past? Y / N How long? _____