

DEXA: PATIENT HISTORY QUESTIONNAIRE

Name:		Menopause Age:	Current Height:	Weight:	Maximal Height:
<input type="radio"/> NO	<input type="radio"/> YES	Have you ever broken a bone as an adult, including hip or vertebra?			
<input type="radio"/> NO	<input type="radio"/> YES	If yes, did the injury result from significant trauma (i.e., auto accident)?			
<input type="radio"/> NO	<input type="radio"/> YES	Did either of your parents ever have a hip fracture?			
<input type="radio"/> NO	<input type="radio"/> YES	Do you currently smoke?			
<input type="radio"/> NO	<input type="radio"/> YES	Have you ever taken Glucocorticoids (steroids) for more than 3 months in total?			
<input type="radio"/> NO	<input type="radio"/> YES	Do you have rheumatoid arthritis?			
<input type="radio"/> NO	<input type="radio"/> YES	Do you have secondary osteoporosis? (i.e., type 1 diabetes, untreated long standing hyperthyroidism, chronic liver disease)			
<input type="radio"/> NO	<input type="radio"/> YES	Do you drink 3 or more alcoholic drinks per day?			
<input type="radio"/> NO	<input type="radio"/> YES	Are you being treated for Osteoporosis?			
<input type="radio"/> NO	<input type="radio"/> YES	Have you ever had surgery to your spine or hips?			
Have you taken any of the following medications?					
<input type="radio"/> Actonel(i.e. Risedronate)		<input type="radio"/> Boniva (i.e. Ibandronate)			
<input type="radio"/> Evista (i.e. Raloxifene)		<input type="radio"/> Forteo (i.e. Teriparatide/Parathyroid hormone)			
<input type="radio"/> Fosamax (i.e. Alendronate)		<input type="radio"/> HRT (i.e. Estrogen/ hormone therapy)			
<input type="radio"/> Miacalcin (i.e. Calcitonin)		<input type="radio"/> Reclast (i.e. Zoledronic)			
<input type="radio"/> Prolia (i.e. Denosumab)		<input type="radio"/> Chemotherapy			
<input type="radio"/> Tamoxifen		<input type="radio"/> Arimidex (i.e. Anastrozole)			
<input type="radio"/> Femara		<input type="radio"/> Medication for seizures or epilepsy			
<input type="radio"/> Medication to prevent organ transplant rejection		<input type="radio"/> Medication for prostate cancer			
<input type="radio"/> Testosterone		<input type="radio"/> Multivitamin			
<input type="radio"/> Vitamin D		<input type="radio"/> Calcium			
<input type="radio"/> Other please specify					
Do you have any of the following medical conditions:					
<input type="radio"/> Anorexia or Bulimia		<input type="radio"/> Any seizure disorder			
<input type="radio"/> Asthma or emphysema		<input type="radio"/> End stage renal disease			
<input type="radio"/> Inflammatory bowel diseases		<input type="radio"/> Hyperparathyroidism			
<input type="radio"/> Hysterectomy		<input type="radio"/> Liver Disease			
<input type="radio"/> Insulin dependent diabetes mellitus		<input type="radio"/> Other Please specify			
<input type="radio"/> NO	<input type="radio"/> YES	Do you perform weight bearing exercise regularly?			
<input type="radio"/> NO	<input type="radio"/> YES	Do you regularly consume dairy products?			
<input type="radio"/> NO	<input type="radio"/> YES	Do you drink caffeinated beverages?			