HDI High Desert Imaging

DEXA SCREENING FORM **MRN#_____**

Patient Name:_____ **Date:**_____

Date of Birth:_____ **Ethnicity:**_____ **Referring Physician:**_____

		YES	NO
1.	Have you had a previous hip of vertebral fracture?	☐	☐
2.	Do you have any metal in your lower back or left hip?	☐	☐
3.	Have you had any fractures during your adult life which did not result From significant trauma? (auto accident?)	☐	☐
4.	Did either of your parents ever have a hip fracture?	☐	☐
5.	Do you smoke?	☐	☐
6.	Have you ever taken Glucocorticoids?	☐	☐
7.	Do you have rheumatoid arthritis?	☐	☐
8.	Do you have secondary osteoporosis?	☐	☐
9.	Do you drink 3 or more alcoholic drinks per day?	☐	☐
10.	Are you being treated for osteoporosis?	☐	☐

11. 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):_____

12. Do you have any of the following medical conditions:

☐ Anorexia of Bulimia	☐ Any seizure disorder
☐ Asthma or Emphysema	☐ Cancer
☐ End stage renal disease	☐ Inflammatory bowel diseases
☐ Hyperparathyroidism	☐ Hysterectomy
☐ Other (please specify):_____	

13. What was your maximum height? _____ in

14.	Do you perform weight-bearing exercise regularly?	☐ **YES** ☐ **NO**
15.	Do you regularly consume beverages?	☐ **YES** ☐ **NO**
16.	Do you drink caffeinated beverages?	☐ **YES** ☐ **NO**

IF FEMALE

17. At what age did your period start? _____

18. How many full term pregnancies have you had? _____

19.	Are you premenopausal?	☐ **YES** ☐ **NO**
20.	Have you ever missed your period for more than 6 months In a row (not including pregnancy or menopause)?	☐ **YES** ☐ **NO**