MINOR & JAMES
MEDICAL

SWEDISH Health Partner

DXA Osteoporosis Questionnaire

Name Date

Referring Clinician

Date Of Birth MRN# Ethnic/Race Background ________

Tallest Height ________ Today's Height ________ Weight ________ Sex Female __ Male __

Part I

Why did your clinician think your bone density & fracture risk should be assessed with this test ?

PLEASE NOTIFY STAFF TO RESCHEDULE YOUR EXAM IF YOU :

________ have had a nuclear medicine or contrast material test in the last two weeks.
________ might be pregnant.

Part II

Please check medical condition that you have or had in past.

________ Osteoporosis
________ Kyphosis (Dowager's hump)
________ Hyperparathyroidism (high blood calcium)
________ Kidney Problems
________ High Thyroid, Goiter, Nodule, Cancer
________ Stomach/ Intestine Surgeries
________ Anorexia or Bulimia
________ Other Bone Diseases (Please list)
________ Lactose Intolerance
________ Rheumatoid Arthritis
________ Other Inflammatory Arthritis (i.e. Lupus,Sjogren's)
________ Degenarative/Osteo Arthritis
________ Curvature of Spine (Scoliosis)
________ Spine or hip surgery
________ Breast Cancer
________ Other Cancer
________ Polio - if so, which limbs were affected
________ Vitamin D deficiency

Please check if you :

________ have relatives with osteoporosis
________ have fallen more than once this year.
________ have balance/equilibrium problems.

Please check if you :

Now **Past**

____ ____ Consume more than three alcoholic drinks each day
____ ____ Use tobacco products

Please estimate your total calcium intake

Number of servings or pills per day.

Milk 8oz. ______ Vegetables ______
Yogurt 8oz. ______ Plain calcium pills ______
Cheese 1oz. ______ Calcium + Vit D pills ______
Cottege Cheese ______ Multivitamin ______
Fruits ______ Vitamin D pills ______

Please check if you have broken any of these bones during adulthood:

______ Spine ______ Wrist ______ Pelvis ______ Hip ______ Rib ______ Other

Please explain the way you were injured ________________________________

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Part III

Please indicate any medications you take or have taken	Previously Used	Currently Use	Dose (if known)
Estrogen (Premarin, Prempro, FemHRT, Estradiol etc.)			
Estrogen blockade (Arimidex, anastrozole), (Aromasin, exemestane), (Femara, letrozole)			
Steroids (hydrocortisone, prednisone, inhaled steroids) for a period greater than one month			
Chemotherapy for cancer			
Dilantin (phenytoin), Tegretol (carbamazepine), or lubinal (phenobarbital)			
Testosterone Injections or Androgel			
Depo Provera Injections			
Evista (Raloxifen)			
Nolvadex, Tamone (Tamoxifen)			
Hydrochlorothiazide (Diazide, Maxide, HCTZ)			
Fosamax (alendronate), Actonel (risedronate), Didronel (etidronate), Boniva (ibandronate)			
Calcitonin (injection), Miacalcin (nasal spray)			
Aredia (pamidronate IV), Zometa (zoledronic acid IV)			
Forteo (teriparatide)			
Gastric Acid Inhibitors (Tagemet, Pepcid, Prilosec, Nexium, etc.)			

How many times do you exercise 20 or more minutes per week? Circle Please

0 per week   1-2 times per week   3-4 times per week   more than 5 times per week

What type of exercise do you do ? (i.e. walking, jogging, biking, swimming etc.) ____________________

____

Part IV **Women Only**

Please answer below :

Are you in menopause? (If uncertain answer 'No') ________ No ________ Yes

What was the age of menopause? ________
What was the date of your last period? ________
What was the number of periods you had in the last year? ________
Have you had a hysterectomy? ________
Do you still have your ovaries? ________

Thank you for completing this questionnaire. A physician will review this questionnaire and your scan. A report will be sent to your physician.