Advanced Imaging Centers | Ocala Health

BONE DENSITOMETRY QUESTIONNAIRE

Today's Date: _____

Patient Name: _____ **Acct.:** _____

1. Have you had a previous bone density (DEXA)? YES NO
   a. If yes, WHEN? _____ WHERE? _____
2. Have you ever broken your spine/vertebrae? YES NO
   a. If yes, did you have a spinal cord injury? YES NO
   b. If yes, please explain any surgical repairs. _____
3. Have you ever broken your hip(s)? YES NO
   a. If yes, which side(s)? RIGHT LEFT
   b. If yes, please explain any surgical repairs. _____
4. Is there a FAMILY history of osteoporosis? YES NO
5. Have you had a nuclear medicine bone scan in the last 7 days? YES NO
6. Have you had an exam using barium in the last 7 days? YES NO
7. What is your ethnic background? _____

Please check all that apply to the following PERSONAL history questions:

- ☐ Hysterectomy
- ☐ Removal of one or both ovaries (Oophorectomy)
- ☐ Osteoporosis (Medication: _____)
- ☐ Post-Menopausal
- ☐ Hyperthyroidism
- ☐ Parathyroid Disease
- ☐ Smoker

Please check all that apply to the following medications for current and/or prior use:

- ☐ Calcium
- ☐ Natural Hormone Replacements (HRT)
- ☐ Anti-Convulsants
- ☐ Antacids
- ☐ Hormone Replacements (Estrogen)
- ☐ Hormone Contraceptives (Birth Control Pills)
- ☐ Steroids (including inhalers)

Tech Initials: _____