



Mountaineer Imaging

Patient Questionnaire DEXA Scan

Name: _____

Date of Birth _____ Sex: M or F Race _____

Height _____ Weight _____

Please answer the following questions to the best of your ability:

If any of the following are true for you, please check the box:

Advanced Age (65 or older)		Hyperparathyroidism	
Inadequate physical activity		History of Rheumatoid arthritis	
Poor health / Frailty		Low calcium intake	
Both ovaries removed		History of osteoporosis	
Caucasian Race		History of Cushing's Syndrome	
Early Menopause (before age 42)		Recurrent Falls	
Family history of fractures (broken bones)		Kidney problems	
Family history of osteoporosis		Age of menopause	
Height loss		Prolonged times without having a period	
Weight loss greater than 10 lbs. less than 1 year		Cigarette smoker	
Low body weight (under 127 lbs.)		Excessive caffeine intake (24 oz less than 24 hrs.)	
History of fractures as an adult Which one(s):		Dementia (Alzheimer's Disease)	
History of liver disease		Asthma	
Hyperthyroidism		High cholesterol	

Do you use any of the following substances?

Steroids		Multivitamin	
Anticonvulsants		Calcium supplement	
High blood pressure medicine		Vitamin D	
Fosamax (medicine for bone loss)		Fluoride	
Hormone or ERT(estrogen replacement therapy)		Cholesterol medicine	
Prednisone		Antidepressant	
Thyroid medicine			

Have you had a nuclear medicine study performed in the last 72 hours? _____

Any additional comments? _____

Have you had a previous DEXA scan? _____ Where? _____