Teton Radiology *advanced medical imaging*
2001 S. Woodruff, Suite 17, Idaho Falls, ID 83404 • tel (208) 524-7237 425 E. 4th N., Rexburg, ID 83440 • tel (208) 356-4888

DXA Patient Questionnaire

Patient name

Date | Medical Record Number

☐ Yes ☐ No Is there a chance you are pregnant?

☐ Yes ☐ No Have you had a barium x-ray in the last 2 weeks?

☐ Yes ☐ No Have you had a nuclear medicine scan or injection of an x-ray dye in the last week?

☐ Yes ☐ No Have you had hyperparathyroidism or a high calcium level in your blood?

If you answered yes to any of the above, speak to our receptionist right away.

☐ Male ☐ Female Age: _____

Your ethnicity (check one) ☐ Caucasian (white) ☐ Black ☐ Aboriginal ☐ Asian ☐ Hispanic ☐ Other

Your country of birth: _____

☐ Yes ☐ No Have you ever had a bone density test?

If yes, when and where: _____

☐ Yes ☐ No Have you had a recent weight change?

If yes, tell us about it: _____

Your tallest height (late teens or young adult): _____

☐ Yes ☐ No Have you ever broken a bone?

Bone Broken	Simple Fall?	If not simple fall, please describe the circumstances	Age

☐ Yes ☐ No Has a parent or sibling had a broken hip from a simple fall or bump?

☐ Yes ☐ No Has a parent or sibling had any other type of broken bone from a simple fall or bump?

☐ Yes ☐ No Have you fallen in the last year?

If yes, how many times have you fallen in the last year? _____

☐ Yes ☐ No Have you ever had surgery of the spine, hips, legs or arms?

If yes, describe what type of surgery you had and which side was affected

_____

☐ Yes ☐ No Are you currently receiving or have you previously received prednisone pills (cortisone)?

If yes, ☐ Currently ☐ Previously

If currently, for how long: _____ what is your dose?_____ mg or _____ pills each day

If previously, for how long: _____ what was your dose?____ mg or _____ pills each day

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DXA Patient Questionnaire

☐ Yes ☐ No Do you have any chronic medical conditions?

If yes, please list: _____

_____

_____

☐ Yes ☐ No Are you currently receiving or have you previously received any of the following medications?

Medication	Yes	No	For how long?
Medication for seizures or epilepsy			
Chemotherapy for cancer			
Medication for prostate cancer			
Medication to prevent organ transplant rejection			

☐ Yes ☐ No Have you been treated with any of the following medications?

Medication	Ever?	Currently?	If current, how long?
Hormone replacement therapy (Estrogen)			
Tamoxifen			
Raloxifene (Evista)			
Testosterone			
Etidronate (Didronel/Didrocal)			
Alendronate (Fosamax)			
Risedronate (Actonel)			
Intravenous pamidronate (Aredia)			
Clodronate (Bonefos, Ostac)			
Calcitonin (Miacalcin nasal spray)			
PTH (Forteo)			
Zoledronic acid (Zometa)			
Sodium fluoride (Fluotic)			

How many servings of the following do you eat/drink per day (on average)?

	Milk (8 oz.)	Calcium-fortified orange juice (8 oz.)	Yogurt (4 oz.)	Cheese (2 oz.)
Servings				

☐ Yes ☐ No Do you take any calcium supplements (including TUMS)?

☐ Yes ☐ No Do you take any vitamin D supplements (including multivitamins and halibut liver oil)?

☐ Yes ☐ No Do you smoke?

For women only …

☐ Yes ☐ No Are you still having menstrual periods?

☐ Yes ☐ No Before menopause, have you ever missed your periods for 6 months or more, besides during pregnancy?

☐ Yes ☐ No Have you had your menopause? If yes, at what age? _____

☐ Yes ☐ No Have you had a hysterectomy? If yes, at what age? _____

☐ Yes ☐ No Have you had both of your ovaries removed? If yes, at what age? _____