



SEDGWICK COUNTY

H E A L T H C E N T E R

Bone Density (DEXA) SCAN Questionnaire

NAME: _____ DOB: _____ AGE: _____ DATE: _____

RACE (circle one): White Black Hispanic Asian Other: _____ Sex: **M** or **F**

Physician: _____ Height (in): _____ Weight (lbs): _____

Prior DEXA imaging? Circle one: NO YES - if so, when? _____

Name of facility last DEXA imaging was done at: (if applicable) _____

For Women Only

Date of your last menstrual period: _____

Have you ever had a hysterectomy? **Y** or **N** If yes, when? _____

Have your ovaries been removed? **Y** or **N** If yes, when? _____

Have you been through menopause? **Y** or **N** If yes, what age were you? _____

PERSONAL HISTORY

- Do you drink alcoholic beverages? **Y** or **N** If yes, how many per day? _____
- Do you smoke? **Y** or **N** If yes, how many cigarettes per day? _____ For how many years? _____
If you have quit smoking, for how many years did you smoke? _____

MEDICAL HISTORY

- Have you ever had any of the following illnesses:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Hyperparathyroidism | <input type="checkbox"/> Chronic Kidney Disease | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Paget's Disease | <input type="checkbox"/> Hyperthyroid | <input type="checkbox"/> Chronic Liver Disease | <input type="checkbox"/> Anorexia/Bulimia |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Hypothyroid | <input type="checkbox"/> Cushing's Disease | <input type="checkbox"/> Rheumatoid Arthritis |
| | <input type="checkbox"/> Malabsorption | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Breast Cancer |

- Do you have a family history of osteoporosis? **Y** or **N** If yes, who? _____
- Parent with a hip fracture? **Y** or **N**
- Please list all surgeries and give dates.

MEDICAL HISTORY(continued)

- Please list all current and/or past fractures

Location

Date

Cause

MEDICATION HISTORY

- Please list all medications you are currently taking including dosage and number of times taken daily. Include vitamins and over the counter medications.
- Have you ever taken any of the following medications?

Steroids: **Y** or **N**

Started:_____ Duration:_____

Osteoporosis Medications: **Y** or **N**

Started:_____ Duration:_____