OVERLAKE ARTHRITIS & OSTEOPOROSIS CENTER, PLLC
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DEXA Questionnaire (ALL DEXAs MUST SIGN ABN OR SCAN CANNOT BE DONE)

PATIENT NAME:_____ DATE OF BIRTH:_____

TODAY'S DATE:_____

Please answer the following questions by marking the appropriate box on the right. Additional information may be written below each section.

GYNECOLOGIC HISTORY (WOMEN ONLY)	YES	NO	UNKNOWN
Are/were your menstrual periods regular between ages 18-40?			
Did you ever have intervals without menstrual periods besides pregnancy?			
Have you had a hysterectomy? If so, what year?			
If a hysterectomy was performed, were the ovaries also removed?			
Have you entered menopause? If so, what year?			

Additional information:

MEDICATION HISTORY	YES	NO	UNKNOWN
Are you now taking hormone replacements or patches?			
Do you take prednisone/other steroids for treatment of arthritis or asthma?			
Do you take medicine for seizure disorders?			
Do you ever take sleeping pills? If so, how often?			
Do you take thyroid medication?			
Do you take alendronate(Fosamax), Actonel, Boniva, Reclast, or Prolia?			

Additional information:

LIFESTYLE HISTORY	YES	NO	UNKNOWN
Do you smoke cigarettes? If so, how many packs per day?			
Do you drink alcoholic beverages? Drinks per day?			
Do you exercise regularly? Amount per day?			

Additional information:

FRACTURE AND FALL HISTORY	YES	NO	UNKNOWN
Have you broken any bones *as an adult*?			
YEAR: SITE: HOW?			

Additional information:

OSTEOPOROSIS-RELATED HISTORY	YES	NO	UNKNOWN
Does anyone in your immediate family have osteoporosis?			
☐ MOTHER ☐ FATHER ☐ SISTER(s) ☐ BROTHER(s)			
Does anyone in your family have a history of hip fracture?			
☐ MOTHER ☐ FATHER ☐ SISTER(s) ☐ BROTHER(s)			

Additional information: