UNIVERSITY RADIOLOGY

DEXA (DUAL-ENERGY X-RAY ABSORPTIOMETRY) QUESTIONNAIRE

Patient Name: _____ Date: _____

Sex: ☐ Female ☐ Male Weight: _____ Height: _____

Please select the ethnicity that **BEST** describes you:

☐ African-American ☐ Asian ☐ Caucasian ☐ Hispanic

Prior **lower** spine or hip surgery?	☐ Spine	☐ Hip	☐ None
Cement (Vertebroplasty/Kyphoplasty) in lower spine?		☐ Yes	☐ No / Unsure
Do you have HYPERPARATHYROIDISM?		☐ Yes	☐ No / Unsure
Are you left-handed or right-handed?		☐ Left	☐ Right

If you are a **male** with prostate cancer, are you taking medications to **lower** male hormones (e.g. Lupron, Zoladex, Trelstar, Viadur, Vantas, Eligard, Synarel)? ☐ Yes ☐ No or N/A

If you are a **female**, are you (select one):

☐ Pre-menopausal (I usually have regular menstrual periods)

☐ Peri-menopausal (Irregular periods, but I have had at least 1 period in the past 12 months)

☐ Post-menopausal (I have NOT had a menstrual period for more than 12 months) **or** Hysterectomy

What is the approximate age of menopause/hysterectomy? _____

Is there any possibility that you are pregnant? ☐ Yes ☐ No or N/A

If pregnancy is possible, when was the last day of your menstrual cycle? _____

Are you currently taking any of the following supplements (Select all that apply):

Calcium (e.g. Tums, **Citracal**, **Caltrate**, **Os-Cal**)	☐ Yes	☐ No / Unsure
Vitamin D (e.g. Calciferol, **Caltrate**, **Citracal**, **Os-Cal**, Calcium**+D**)	☐ Yes	☐ No / Unsure

Are you currently, or have you ever taken the following medications?	Year Began/Ended		
Alendronate (**Fosamax**/Fosamax+D)	_____	☐ Yes	☐ No / Unsure
Risedronate (**Actonel**/Atelvia)	_____	☐ Yes	☐ No / Unsure
Ibandronate (**Boniva**)	_____	☐ Yes	☐ No / Unsure
Raloxifene (**Evista**)	_____	☐ Yes	☐ No / Unsure
Denosumab (**Prolia**)	_____	☐ Yes	☐ No / Unsure
Teriparatide (**Forteo**)	_____	☐ Yes	☐ No / Unsure
Zoledronic Acid (**Reclast**/Aclasta/Zometa)	_____	☐ Yes	☐ No / Unsure
Abaloparatide (**Tymlos**)	_____	☐ Yes	☐ No / Unsure
Estrogen/Hormone Replacement Therapy (e.g. **Duavee**)	_____	☐ Yes	☐ No / Unsure
Other Osteoporosis Medication Treatment:	_____	☐ Yes	☐ No / Unsure
☐ _____			

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FRAX Questionnaire

Do you drink 3 or more units of alcohol daily?		☐ Yes	☐ No / Unsure
Hip fracture in your father or mother?		☐ Yes	☐ No / Unsure
Currently or EVER taken ORAL/IV steroids (e.g. prednisone/cortisol) for more than 3 months? (equivalent dose of prednisone 5mg or more daily) (topical/inhaled steroids are **not** applicable)	Med/Dose: _____	☐ Yes	☐ No / Unsure
Have you suffered a **wrist/hip/spine** fracture in your **ADULT** life which occurred **spontaneously or** arising from **low-impact trauma or fall from normal standing height**?		☐ Yes	☐ No / Unsure
Do you have any reason for secondary osteoporosis? (e.g. hyperparathyroidism, **type I** diabetes, cystic fibrosis, osteogenesis imperfecta, untreated long-standing hyperthyroidism, hypogonadism or premature menopause (<45 years), chronic malnutrition/malabsorption, chronic liver/kidney disease, multiple myeloma)		☐ Yes	☐ No / Unsure
Have you been diagnosed with **RHEUMATOID** Arthritis?		☐ Yes	☐ No / Unsure
Do you currently smoke?		☐ Yes	☐ No

Patient Signature _____ Date _____

Tech/Nurse Signature _____ Date _____

OFFICE USE ONLY:

Pregnancy Test Result: ☐ Positive ☐ Negative ☐ N/A

v2017.1