THE IMAGING CENTER
DEXA SCREENING FORM

Sex: ○ **Female** ○ **Male** **Menopause Age:** ☐

Current Height: ☐ **Ethnicity:** (This information is necessary for the software to analyze your scan)

Weight: ☐ ○Caucasian ○African-American ○Asian ○Hispanic ○ Other_____

1. Have you had a previous hip or vertebral (spine) fracture? ---------- ○ **Yes** ○ **No**

   Hip replacement or surgery? ☐Left ☐Right **Metal in lower spine?** ☐Yes ☐No

2. Have you had any fractures during your adult life which did **not** result from significant trauma? ---------- ○**Yes** ○ **No**
3. Did either of your parents ever have a hip fracture? ---------- ○**Yes** ○ **No**
4. Do you smoke? ---------- ○**Yes** ○ **No**
5. Have you taken Glucocorticoids and/or any long term steroids? ---------- ○**Yes** ○ **No**
6. Do you have rheumatoid arthritis? ---------- ○**Yes** ○ **No**
7. Do you have secondary osteoporosis (osteoporosis caused from another disease)? ---------- ○**Yes** ○ **No**
8. Do you drink 3 or more alcoholic drinks per day? ---------- ○**Yes** ○ **No**
9. Are you currently being treated for osteoporosis? ---------- ○**Yes** ○ **No**

10. Have you **ever** taken any of the following medications and/or supplements?
    - ☐ Actonel
    - ☐ Boniva (i.e. ibandronate)
    - ☐ Evista (i.e. raloxifene)
    - ☐ Forteo (i.e. parathyroid hormone)
    - ☐ Fosamax (i.e. alendronate)
    - ☐ HRT (i.e. estrogen/hormone therapy)
    - ☐ Miacalcin (i.e. calcitonin)
    - ☐ Protelos (i.e. strontium ranelate)
    - ☐ Reclast (i.e. zoledronate)
    - ☐ Prolia (i.e. denosumab)
    - ☐ Vitamin D
    - ☐ Calcium
    - ☐ Other-please specify: ☐

11. Do you have **or** have you **ever** had any of the following?
    - ☐ Anorexia or Bulimia
    - ☐ Any Seizure Disorders
    - ☐ Asthma or Emphysema
    - ☐ Cancer Type(s): _____
    - ☐ End stage renal disease
    - ☐ Inflammatory bowel diseases
    - ☐ **Hyperparathyroidism**
    - ☐ Hysterectomy Age: _____
    - ☐ Other-please specify: ☐

12. What was your tallest or maximum height? ---------- ☐
13. Do you perform weight bearing exercise regularly? ---------- ○**Yes** ○ **No**
14. Do you regularly consume dairy products? ---------- ○**Yes** ○ **No**
15. Do you drink caffeinated beverages? ---------- ○**Yes** ○ **No**

If female:

16. At what age did your period start? ---------- ☐
17. Are you **pre**menopausal? ---------- ○**Yes** ○ **No**
18. Have you ever missed your period for more than 6 months in a row? ---------- ○**Yes** ○ **No** (not including pregnancy or menopause)