

ZWANGER-PESIRI RADIOLOGY, LLP
DEXA (Bone Density) Questionnaire

Name of Patient: _____ **Date:** _____

Reason for this DEXA (Bone Density) exam: _____

Yes/No Have you had this test before? Where? _____

What were the results? _____

Yes/No Have you been diagnosed with osteoporosis by x-ray or ultrasound?

Past Medical History:

Yes/No Are you currently being treated for hyper parathyroidism?

Yes/No Do you have Cushing's syndrome?

Yes/No Do you have a family history of osteoporosis?

Yes/No Have you had any fractures of your spine (vertebrae) , hips, or wrists?

Yes/No Have you had an oophorectomy (removal of the ovaries)?

Menstrual History:

Age of first menses? _____

Yes/No Do you still have regular menstrual periods?

Yes/No Are you currently undergoing menopause?

Yes/No Are you post-menopausal?

Current Medications:

Yes/No Are you currently on hormonal replacement therapy? If yes, How long? _____

Yes/No Are you taking steroids such as prednisone?

Yes/No Are you taking synthroid?

Yes/No Are you currently or previously on chemotherapy?

Yes/No Are you taking Fosamax, Actonel, Boniva or other osteoporosis medications?

Please list all medications you are currently taking: _____

Patient Signature

Date