

DEXA FORM

Osteoporosis Risk Factor Survey

Name: _____ Date of Exam: _____

Race: Asian ___ White ___ Black ___ Other ___ Date of Birth: _____

Height: _____ Weight: _____

Medications: _____

Date and Location of the Last Bone Density: _____

Have you had a hysterectomy? Yes No

Do you have a family history of Osteoporosis? Yes No

Do you smoke tobacco? Yes No

Do you drink alcohol? Yes No

Do you exercise? Yes No

Is your diet low in dairy products and other sources of calcium? Yes No

Are you a postmenopausal woman? Yes No

If yes, when did you start menopause? _____

Do you take estrogen/progesterone medication? Yes No

Did you ever fracture your hip? Yes No

If yes, when? _____

Did you ever fracture your spine? Yes No

If yes, when? _____

Did you ever fracture your wrist? Yes No

If yes, when? _____

Did you have other fractures since age 50? Yes No

Have you had surgery on your hip? Yes No

Have you had surgery on your spine? Yes No

Have you had surgery on your wrist? Yes No

Have you lost more than 2 inches in height since high school? Yes No

Do you have hyperparathyroidism? Yes No

Do you have hyperthyroidism? Yes No

Do you take thyroid medication regularly? Yes No

Do you take Prednisone or other steroids regularly? Yes No