ADVANCED IMAGING CONCEPTS

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 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 post menopausal woman? If yes, when did you start menopause? _____	Yes	No
Do you take estrogen/progesterone medication?	Yes	No
Did you ever fracture your hip? If yes, when? _____	Yes	No
Did you ever fracture your spine? If yes, when? _____	Yes	No
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 or hyperthyroidism? (Circle one)	Yes	No
Do you take thyroid medication regularly?	Yes	No
Do you take Prednisone or other steroids regularly?	Yes	No

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