Central Georgia Breast Care Center
Dexa Scan Questionnaire

Name:

Birth Date:

Today's Date:

HAVE YOU HAD ANY X-RAYS IN THE PAST WEEK IN WHICH YOU HAD IV CONTRAST OR BARIUM? If so, tell the receptionist now. This may interfere with this test and you may need to be rescheduled.

Have you had a bone density (DEXA Scan) before? ☐no ☐yes

If so, When? Where?

What were the results?

Medical History

1. How tall are you? feet inches

2. How much do you weigh? pounds

3. Have you had any broken bones as an adult? ☐no ☐yes
4. Have you had back surgery? ☐no ☐yes
5. Have you had hip surgery? ☐no ☐yes
   Do you have metal pins in your back or hips? ☐ n/a ☐no ☐yes

Indications

1. Have you had cancer? ☐no ☐yes

If so, what kind? _____

Did you have chemo?	☐n/a	☐no ☐yes
Did you have radiation?	☐n/a	☐no ☐yes
2. Have you had thyroid disease?		☐no ☐yes
If so, have you taken medication for it?	☐n/a	☐no ☐yes
3. Have you used prednisone or any steroid medication?		☐no ☐yes
4. Are you a smoker/tobacco user?		☐no ☐yes
5. Do you have a family history of osteoporosis?		☐no ☐yes

Treatments

1. Are you taking calcium supplements?		☐no ☐yes
If so, do they contain Vitamin D?	☐n/a	☐no ☐yes
2. Are you taking a multivitamin?		☐no ☐yes
3. Are you taking any prescription medicine for osteoporosis?		☐no ☐yes