SDMI STEINBERG DIAGNOSTIC

FEMALE INTAKE QUESTIONNAIRE
DEXA SCAN

First Name _____ Last Name _____ DOB/Age _____

Allergies/Include reaction(s) _____

Height _____ Weight _____ Patient# (Internal use only) _____

Ethnicity/Nationality (*For purpose of fracture risk calculation*) _____

REASON FOR EXAM *(Please include symptoms and time frame):*

Previous Imaging/surgeries Related to Todays Exam	**Date**

TECH NOTES *(for internal use only)*:

Oral (i.e. Barium)/IV contrast or Nuc Med Test in the last 2 weeks? ☐ Yes ☐ No

Additional Tech Notes:

Have you ever had a bone density test? ☐ Yes ☐ No If yes, when/where? _____

Bone fracture as an adult? ☐ Yes ☐ No If yes, location of fracture: _____ **when?** _____

Injury details: _____

Hip fracture in mother or father? ☐ Yes ☐ No If yes, age when fracture occured: _____

Injury details: _____

Ever had surgery on your spine, hips, or arms? ☐ Yes ☐ No If yes, please specify location: _____

When? _____ **Reason for surgery:** _____

Uterus removed (Hysterectomy)? ☐ Yes ☐ No If yes, what age? _____

Ovaries Removed? ☐ Left ☐ Right ☐ Both ☐ No If yes, what age? _____

Have you gone through menopause? ☐ Yes ☐ No ☐ Not sure If yes, what age? _____

If no, date of last cycle: _____ **If not sure, explain:** _____

Previously diagnosed with Osteoporosis? ☐ Yes ☐ No If yes, when/where? _____

Previously diagnosed with Osteopenia? ☐ Yes ☐ No If yes, when/where? _____

Ever diagnosed with Secondary Osteoporosis? ☐ Yes ☐ No If yes, when? _____

Ever diagnosed with Rheumatoid Arthritis (not *Osteoarthritis)* ☐ Yes ☐ No If yes, when? _____

Are you a smoker? ☐ Yes ☐ No Do you consume 3 or more alcoholic drinks per day? ☐ Yes ☐ No

Are you taking any of the following medication(s) to treat Low Bone Density? (check all that apply):

☐ Risedronate (Actonel) ☐ Alendronate (Fosamax) ☐ Zoledronic Acid (Reclast) ☐ Pamidronate (Aredia)

☐ Etidronate (Didronel) ☐ Ibandronate (Boniva) ☐ Denosumab (Prolia) ☐ Other: _____

Are you taking Calcium/Vitamin D? ☐ Yes ☐ No If yes, how long? _____

Ever taken Estrogren/Testosterone or Hormone Replacement? ☐ Yes ☐ No If yes, please specify the following:

Type: _____ **Dose:** _____ **How often:** _____

Ever taken glucocorticoid pills (e.g. prednisone) > 3 months? ☐ Yes ☐ No If yes, please specify the following:

Type: _____ **Dose:** _____ **How often:** _____

I agree that the above information is correct *(Do not fill out until after technologist has reviewed):*

Patient Signature: _____ Todays Date: _____