DuPage Medical Group

DIAGNOSTIC IMAGING

DEXASCAN SCREENING FORM
Patient History Questionnaire

Name: _____

Date of Birth: _____

Current Height (in) _____

Weight: (lb) _____

Ethnicity: _____

Females: Menopause Age: _____

1. Have you had a previous hip or vertebral fracture?	___ Yes	___ No
2. Have you had any fractures during your adult life which did not result from significant trauma (e.g. auto accident)?	___ Yes	___ No
3. Did either of your parents ever have a hip fracture?	___ Yes	___ No
4. Do you smoke?	___ Yes	___ No
5. Have you ever taken Glucocorticoids or Steroids (oral)	___ Yes	___ No
6. Do you have rheumatoid arthritis?	___ Yes	___ No
7. Do you have secondary osteoporosis?	___ Yes	___ No
8. Do you drink 3 or more alcoholic drinks per day?	___ Yes	___ No
9. Are you being treated for osteoporosis?	___ Yes	___ No
10. Have you had any surgery to your lumbar spine or left hip?	___Yes	___ No

11. Have you ever taken any of the following medications in the last 2 years:

__ Actonel (i.e. risedronate)
__ Boniva (i.e. ibandronate)
__ Evista (i.e. raloxifene)
__ Forteo (i.e. parathyroid hormone)
__ Fosamax (i.e. alendronate)
__ HRT (i.e. estrogen/hormone therapy)
__ Miacalcin (i.e. calcitonin)
__ Protelos (i.e. strontium ranelate)
__ Relcast (i.e. zoledronate)
__ Prolia (i.e. denosumab)
__ Vitamin D
__ Calcium
__ Other – Please specify: _____

12. Do you have any of the following medical conditions:

__ Hypercalcemia
__ Hysterectomy - Partial or Full
__ Hyperparathyroidism (parathyroid glands)
__ Other – Please specify: _____

13. What was your maximum height (inches)? _____

14. Are you premenopausal? ___ Yes ___ No