

**Marietta Imaging Center**  
DEXA (Bone Density) Questionnaire

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Race:

African American \_\_\_ Asian \_\_\_ Caucasian \_\_\_ Hispanic \_\_\_ Native American \_\_\_\_\_

Sex: Female \_\_\_ Male \_\_\_\_\_

Have you fractured any bones during your adult life? Yes \_\_\_ No \_\_\_

Does your family have a history of osteoporosis? Yes \_\_\_ No \_\_\_

Do you take a calcium supplement daily? Yes \_\_\_ No \_\_\_

Do you exercise at least three times per week? Yes \_\_\_ No \_\_\_

Have you gone through menopause? Yes \_\_\_ No \_\_\_

At what age? \_\_\_\_\_

Do you currently take any of the following medications?

Steroids (prednisone, cortisone, etc) Yes \_\_\_ No \_\_\_

Thyroid Medication Yes \_\_\_ No \_\_\_

Estrogen Yes \_\_\_ No \_\_\_

Fosamax Yes \_\_\_ No \_\_\_

Calcium replacement medication Yes \_\_\_ No \_\_\_

List any additional medications taken daily \_\_\_\_\_

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Do you have any of the following conditions?

Thyroid disease Yes \_\_\_ No \_\_\_

Hyperparathyroidism Yes \_\_\_ No \_\_\_

Hyperthyroidism Yes \_\_\_ No \_\_\_

Rheumatoid arthritis Yes \_\_\_ No \_\_\_

Have you had bone density exams before? Yes \_\_\_ No \_\_\_

If Yes, where? \_\_\_\_\_

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**FOR OFFICE USE ONLY**

Height \_\_\_\_\_ inches Weight \_\_\_\_\_ lbs. MRN \_\_\_\_\_