

## DEXA QUESTIONNAIRE/AUTHORIZATION

(office use)

Name: \_\_\_\_\_ Date of Exam: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

1. Why are you having this exam? \_\_\_\_\_

2. What is your ethnicity? \_\_\_\_\_

3. Have you fractured a bone as an adult? ☐ Yes ☐ No  
If yes, what bone did you fracture: \_\_\_\_\_

4. History of hip fracture in mother or father? ☐ Yes ☐ No

5. Do you have any implants/metal in your spine or hips? ☐ Yes ☐ No

6. Do you consume 3 or more alcoholic drinks per day? ☐ Yes ☐ No

7. Do you currently use tobacco? ☐ Yes ☐ No

8. Have you ever taken any of the following medications for osteoporosis?

☐ Actonel (i.e. risedronate) ☐ Aromatase Inhibitor (i.e. Anastrozole (Arimidex), Letrozole (Femara), Exemestane (Aromasin))  
☐ Boniva (i.e. ibandronate) ☐ Calcium ☐ Evenity ☐ Evista (i.e. raloxifene)  
☐ Forteo (i.e. parathyroid hormone) ☐ Fosamax (i.e. alendronate) ☐ HRT (i.e. estrogen/hormone therapy)  
☐ Miacalcin (i.e. calcitonin) ☐ Prolia (i.e. denosumab) ☐ Protelos (i.e. strontium ranelate)  
☐ Reclast (i.e. zoledronate) ☐ Tymelos ☐ Vitamin D  
☐ Other \_\_\_\_\_ ☐ None of the Above

9. Do you currently take any glucocorticoids/steroids? ☐ Yes ☐ No  
If yes, have you been taking this medication for 3 or more months? ☐ Yes ☐ No

10. Do you have a history of Rheumatoid Arthritis? ☐ Yes ☐ No

11. Do you have any of the following conditions?

☐ Type I Diabetes ☐ Osteogenesis imperfecta ☐ Untreated or long-standing hyperthyroidism  
☐ Premature menopause (<45 years) ☐ Chronic liver disease (cirrhosis) ☐ Anorexia or Bulimia  
☐ Asthma or Emphysema ☐ End stage renal disease ☐ Hyperparathyroidism  
☐ Any Seizure Disorders ☐ Inflammatory bowel diseases ☐ Cancer  
☐ Hysterectomy ☐ Other \_\_\_\_\_ ☐ None of the Above

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### FEMALE PATIENTS

12. Is there any possibility that you are pregnant?

☐ Yes ☐ No

13. What is your gynecological history?

☐ Premenopausal ☐ Perimenopausal When was your last menstrual cycle? \_\_\_\_\_

☐ Postmenopausal Menopause at Age? \_\_\_\_\_

If you have any questions, please speak to any staff member and they will contact a physician to answer your questions.

I authorize Weill Cornell Imaging at NewYork-Presbyterian, its physicians and other staff to perform the prescribed examination.

Signature of Patient:

(Parent or Guardian) \_\_\_\_\_ Date: \_\_\_\_\_

Front Desk Staff: \_\_\_\_\_ Signature: \_\_\_\_\_

Technologist: \_\_\_\_\_ Signature: \_\_\_\_\_

Nurse: \_\_\_\_\_ Signature: \_\_\_\_\_