Cheyenne Women's Clinic P.C.

DEXA Scan Questionnaire

Name: _____ Nursin g: Height:

DOB: __/__/____ Weight:

Age at Menopause: _____ last period: _____
Are you pregnant? Yes/No Unsure
Have you taken any contrast material within the las t week? Yes/ No
Do you have any surgical hardware such as staples o r implants? Yes/ No
Do you take calcium supplements? Yes/ No Today? Ye s/ No
Do you take any medications? Yes/ No
Current Medications:

Allergies:

Check all items that apply to you:
__ Over 65years of age
__ Not menstruating for more than 6 mo
__ Have had ovaries removed
__ Caucasian
__ Menopause prior to age 45
__ Weight below 125#
__ Low calcium intake (less than 800 mg daily)
__ In poor health
__ Lost over 1.5 inches in height
__ Taking steroids
__ Taking anti-seizure medications
__ History of alcoholism
__ History of dementia
__ History of recurrent falls
__ History of kidney problems
__ Family history of fractures over age 20
__ Family history of osteoporosis
__ Have you had any fractures over the age of 20
__ Diagnosed with Osteopenia
__ Diagnosed with Osteoporosis
__ Smoker --How many packs a day__

Any History of these Conditions:
__ Anorexia or Bulimia
__ Arthritis
__ Asthma
__ Cancer; Type:_____
__ Celiac disease
__ Cerebral Palsy
__ Crohn's Disease
__ Colitis
__ Diabetes
__ Emphysema
__ Endometriosis
__ Gastric Bypass
__ Hyperparathyroidism
__ Hyperthyroidism
__ Liver Disease
__ Lupus
__ Multiple Sclerosis
__ Organ Transplant
__ Scoliosis
__ Thalassemia

Other medical conditions:

Signature:_____ Date:_____ ____