UNIVERSITY RADIOLOGY

DXA (DUAL-ENERGY X-RAY ABSORPTIOMETRY) QUESTIONNAIRE

Patient Name: ______________________________ Date: ______________

Gender Identity: ☐ Female ☐ Male ☐ Transgender Female ☐ Transgender Male ☐ Other: ______________

Sex recorded at birth on your original birth certificate: ☐ Female ☐ Male ☐ Other: ______________

Weight: ______________ Height: ______________

Please select the ethnicity that **BEST** describes you: ☐ African-American ☐ Asian ☐ Caucasian ☐ Hispanic

History:

Prior **lower** spine or hip surgery?	☐ Spine	☐ Hip	☐ None
Cement (Vertebroplasty/Kyphoplasty) in lower spine?		☐ Yes	☐ No/Unsure
Prior silicone injection in buttocks and/or thighs?		☐ Yes	☐ No
Do you have HYPERPARATHYROIDISM?		☐ Yes	☐ No/Unsure
Are you left-handed or right-handed?		☐ Left	☐ Right

Female Patients:

Are you (select one):

☐ Pre-menopausal (I usually have regular menstrual periods)

☐ Peri-menopausal (Irregular periods, but I have had at least 1 period in the past 12 months)

☐ Post-menopausal (I have NOT had a menstrual period for more than 12 months) **or** Hysterectomy

If post-menopausal, what was the approximate age of menopause/hysterectomy? ______________

Is there any possibility that you are pregnant? ☐ Yes ☐ No or N/A

If pregnancy is possible, when was the last day of your menstrual cycle? ______________

Supplements: Are you taking any of the following (select all that apply)

Calcium (e.g. Tums, **Citracal**, **Caltrate**, **Os-Cal**)	☐ Yes	☐ No/Unsure
Vitamin D (e.g. Calciferol, **Caltrate**, **Citracal**, **Os-Cal**, Calcium**+D**)	☐ Yes	☐ No/Unsure

Medications: Are you taking any of the following (select all that apply)

	Year Began/Ended		
Alendronate (**Fosamax**/Fosamax+D)	______________	☐ Yes	☐ No/Unsure
Risedronate (**Actonel**/Atelvia)	______________	☐ Yes	☐ No/Unsure
Ibandronate (**Boniva**)	______________	☐ Yes	☐ No/Unsure
Raloxifene (**Evista**)	______________	☐ Yes	☐ No/Unsure
Denosumab (**Prolia**)	______________	☐ Yes	☐ No/Unsure
Teriparatide (**Forteo**)	______________	☐ Yes	☐ No/Unsure
Zoledronic Acid (**Reclast**/Aclasta/Zometa)	______________	☐ Yes	☐ No/Unsure
Abaloparatide (**Tymlos**)	______________	☐ Yes	☐ No/Unsure
Estrogen/Hormone Replacement Therapy (e.g. **Duavee**)	______________	☐ Yes	☐ No/Unsure
Other Osteoporosis Medication Treatment (specify below):	______________	☐ Yes	☐ No/Unsure

____

Approved. Effective 09.16.2021

UNIVERSITY RADIOLOGY

FRAX Questionnaire:		
Do you drink 3 or more units of alcohol daily?	☐ Yes	☐ No/Unsure
Hip fracture in your father or mother?	☐ Yes	☐ No/Unsure
Currently or EVER taken ORAL/IV steroids (e.g. prednisone/cortisol) for more than 3 months? (equivalent dose of prednisone 5mg or more daily) (topical/inhaled steroids are **not** applicable) If yes, provide name of medication and dosage: ____________	☐ Yes	☐ No/Unsure
Have you suffered a **wrist/hip/spine** fracture in your **ADULT** life which occurred **spontaneously** or arising from **low-impact trauma or fall from normal standing height**?	☐ Yes	☐ No/Unsure
Do you have any reason for secondary osteoporosis? (e.g. hyperparathyroidism, **type I** diabetes, cystic fibrosis, osteogenesis imperfecta, untreated long-standing hyperthyroidism, hypogonadism or premature menopause (<45 years), chronic malnutrition/malabsorption, chronic liver/kidney disease, multiple myeloma)	☐ Yes	☐ No/Unsure
Have you been diagnosed with **RHEUMATOID** Arthritis?	☐ Yes	☐ No/Unsure
Do you currently smoke?	☐ Yes	☐ No

______________________________ ______________
Patient Signature Date

______________________________ ______________
Tech/Nurse Signature Date

OFFICE USE ONLY:

Pregnancy Test Result: ☐ Positive ☐ Negative ☐ N/A

Approved. Effective 09.16.2021