



Women's Imaging Specialists – Gulf Shores
 1229 Gulf Shores Pkwy, Suite 100
 Gulf Shores, AL 36542
 (251) 255-6262 phone / (251) 256-0901 Fax
www.wisgulfshores.com

Patient Questionnaire for DEXA Exam

Name:		Date:
Date of Birth:		MRN:
Height:	Weight:	Referring Physician:
Is there a chance that you are pregnant?		Yes / No
Have you had a barium X-Ray in the last 2 weeks?		Yes / No
Have you had a nuclear medicine scan or injection of an X-Ray dye in the last week?		Yes / No

***If you answered yes to any of the above questions, please speak to our receptionist right away.**

Age:			
Ethnicity (circle one): Caucasian (White) / Black / Asian / Hispanic / Native American / Other			
Reason for Bone Density exam (circle one): Screening / Other Describe:			
Have you ever had a bone density test?			Yes / No
If yes, when and where?			
Have you ever had a broken bone as an adult?			Yes / No
If yes, please describe:			
Has a physician ever told you that you have: Osteoporosis? Yes / No		Osteopenia?	Yes / No
Do you take medication for: Osteoporosis? Yes / No		Osteopenia?	Yes / No
Have you lost height (become any shorter)?			Yes / No
Are you currently receiving or have you previously received prednisone pills (cortisone)?			
Circle:	Yes, currently	Yes, previously	No
If yes, how long?		Dose?	mg per day
Has a physician ever told you that you have Rheumatoid Arthritis			Yes / No
Do you currently take medication for a thyroid condition?			Yes / No
Do you smoke?			Yes / No
Do you consume more than 3 servings of alcohol DAILY?			Yes / No
Have you had surgery on your lower back or hip?			Yes / No
If yes, which hip?			
Do you have a family history of either parent having a hip fracture?			Yes / No
Do you take calcium supplements?			Yes / No
Do you take Vitamin D daily?			Yes / No
Do you take a Multi Vitamin daily?			Yes / No
Are you still having menstrual periods?			Yes / No
Are you post-menopausal?			Yes / No
If yes, at what age?			
Have you ever had a hysterectomy?			Yes / No
Have you had both of your ovaries removed?			Yes / No
If yes, at what age?			

I give my consent to the performance of a bone densitometry scan at Women's Imaging Specialists:

Patient Signature: _____ **Date:** _____