VinCon Diagnostic Center 5732 Canton Cove, Winter Springs, FL 32708

Patient Name: _____ DOB: ____/__/____ Today's date:_____

Dexa Scan Questionnaire

ALL questions must be answered in order to perform your test

Referring Doctor's Name: _____

1. Have you ever had a Bone Density exam before? ___No ___Yes, where? _____ When?_____
2. What is your **height** and **weight**? _____feet _____inches, _____ pounds
3. Ethnicity: Caucasian ____ African American _____ Hispanic _____ Asian_____ Other_____
3. Have you had **surgery on your hips**? __ No, __,Yes If Yes, Which side? Left __ Right ___, Date: ___/___/___
4. Have you had any **lumbar spine surgery**? ___No ___Yes, when? _____
5. Have you had **surgery on your forearms**? ___No ___Yes, when? _____

FOR WOMEN ONLY: **Your Menstrual History:**

Are you still having menstrual periods? ___No ___Yes

If Yes, when was your last menstrual period? _____

If No, and before menopause, have you ever missed periods for 6 months or more, other than during pregnancy? ___No ___Yes

If Yes, reason _____

Ever used Norplant or Depo-Provera? ___No ___Yes
If Yes, when and how long? _____

Have you:
- Had a hysterectomy? ___No ___Yes, Age: _____
- Had your ovaries removed? ___No ___Yes, Age: _____
- Gone through menopause? ___No ___Yes, Age: _____

REMINDER:
MEDICARE Members:
Please note that Medicare will only pay for this exam once every **25** months.

6. Do you have a **family history** of Osteoporosis? ____No ___Yes
7. Have you had any **broken bones/fractures**? ____No ____Yes, Which bone(s)? _____
   When and how did this happen? _____
8. Are you on "**Bone-building**" medications? ____No ____Yes

Fosamax (Alendronate), Miacalcin, Actonel (Risedronate), Reclast IV (Zoledronic acid), Boniva (Ibandronate) , Evista (Raloxifene)

What is/was the name of your medication? _____ *Dosage?*_____

9. Are you currently or have you *EVER* used **corticosteroids**? ____No ____Yes, for the treatment of: _____
   What is/was the name of your medication? _____ *Dosage?*_____
   How long have you been or were you on corticosteroids? _____
10. Do you use **calcium supplements**? ____No____Yes, How much per day? _____
11. Are you on **hormone replacement**? ____No____Yes
    What is the name of your medication? _____ Dosage? _____
12. Are you on **thyroid medications**? ____No ____Yes, for □Hypothyroidism □Other_____
    What is the name of your medication? _____ *Dosage?* _____
13. Are you presently or have you been on **cancer therapy drugs**? ___No ____Yes, to treat: _____
    For Example: *Lupron, Tamoxifen, Raloxifene, Armimidex, Rituxan, etc*
    What is the name of your medication? _____, How long have you been taking this medication? _____

TECHNOLOGIST ONLY: _____

_____

Technologist Signature