TPCA Tallahassee Primary Care Associates

Our primary care is you.

DXA HISTORY AND QUESTIONNARIE

Name: _____ Exam date: _____

Date of Birth: _____ Weight: _____HT (in)_____

Menopause Age: _____ Ethnicity: _____

Referring Physician: _____ Sex: _____ Menopause Age: _____

1. Have you had a previous hip or vertebral fracture? Yes No
2. Have you had any fractures during your adult life which did not result from a trauma? (e.g., car accident) Yes No
3. Did either of your parents have a hip fracture? Yes No
4. Do you smoke? Yes No
5. Have you ever taken Glucocorticoids? Yes No
6. Do you have Rheumatoid Arthritis? Yes No
7. Do you have secondary Osteoporosis? Yes No
8. Do you drink 3 or more alcoholic drinks per day? Yes No
9. Are you currently being treated for Osteoporosis? Yes No
10. Do you perform weight bearing exercise regularly? Yes No
11. Do you regularly consume dairy products? Yes No
12. Do you drink caffeinated beverages? Yes No
13. What was your maximum height in inches? _____

14. Have you ever taken any of the following medications (circle medications)?

Actonel (risedronate) Boniva (ibandronate) Evista (raloxifene)
Fosamax (alendronate) Miraculin (calcitonin) Forteo (parathyroid hormone)
Recast (zoledronate) Protelos (strontium ranelate) Prolia (denosumab)
HRT (estrogen/hormone therapy) Calcium Vitamin D

Any medications to treat depression, anti-anxiety, obsessive-compulsive disorder, posttraumatic stress disorder, social anxiety disorder, and panic disorder. List medication below:

_____

15. Do you have any of the following medical conditions (circle below)?

Anorexia or Bulimia	Asthma or Emphysema	End of stage renal disease
Hyperparathyroidism	Seizure disorder	Cancer
Inflammatory bowel diseases	Hysterectomy	Lupus
Sickle Cell	Acid Reflux	Diabetes
COPD		

Other: _____

If Female:

16. At what age did your menstrual cycle start? _____
17. Are you premenopausal? _____
18. How many full-term pregnancies have you had? _____
19. Have you ever missed your monthly menstrual cycle for more than six months in a row (not including pregnancy or menopause)? _____

Patient signature: _____ Date: _____