Lone Star Arthritis & Rheumatology Associates, P.C.

General Phone (817) 789-6770
Fax (817) 789-6677

DEXA History Form

PATIENT INFORMATION			
PATIENT NAME		**TODAYS DATE**	
HEIGHT (in)	**WEIGHT** (lbs)	**DATE OF BIRTH**	**SEX** ☐ Female ☐ Male
MENOPAUSE AGE	**ETHNICITY**		

	YES	NO
1. Have you had a previous hip or vertebral fracture?	☐	☐
2. Have you had any fractures during your adult life which did not result from significant trauma (e.g., auto accident)?	☐	☐
3. Did either of your parents ever have a hip fracture?	☐	☐
4. Do you smoke?	☐	☐
5. Have you ever taken Glucocorticoids (Prednisone, cortisone) for more than 3 months?	☐	☐
6. Do you have rheumatoid arthritis?	☐	☐
7. Do you drink 3 or more alcoholic drinks per day?	☐	☐
8. Are you being treated for osteoporosis?	☐	☐

9. Have you ever taken any of the following medications?

☐ Actonel (i.e. risedronate) ☐ Boniva (i.e. ibandronate) ☐ Evista (i.e. raloxifene) ☐ Forteo (i.e. parathyroid hormone)

☐ Fosamax (i.e. alendronate) ☐ HRT (i.e. estrogen/hormone therapy) ☐ Miacalcin (i.e. calcitonin)

☐ Protelos (i.e. strontium ranelate) ☐ Reclast (i.e. zoledronate) ☐ Prolia (i.e. denosumab) ☐ Vitamin D ☐ Calcium

☐ Other (please specify)

10. Do you have any of the following medical conditions?

☐ Anorexia or Bulimia ☐ Any Seizure Disorders ☐ Asthma or Emphysema ☐ Cancer ☐ End Stage Renal Disease

☐ Inflammatory Bowel Disease ☐ Hyperparathyroidism ☐ Hysterectomy

☐ Other (please specify)

11. What was your maximum height (in)?

	YES	NO
12. Do you perform weight bearing exercise regularly?	☐	☐
13. Do you regularly consume dairy products?	☐	☐
14. Do you drink caffeinated beverages?	☐	☐
15. Are you pre-menopausal?	☐	☐