DEXA screening Questionnaire

 Patient name

 DOB Height Weight

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| **Which kind of DEXA scan are you having? (Please circle)** **Bone/Osteoporosis Muscle/Body Composition** |

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| --- | --- | --- | --- | --- |
|  | Please tick Yes (If applicable) or NO (If not applicable) | Yes | No | Further details  |
| 1. | Have you had a DEXA scan before? If yes, please provide the date and location if possible. |  |  |  |
| 2.  | Have you had a nuclear medicine scan, barium examination or another imaging procedure where you were given an injection in the last 2 weeks? |  |  |  |
| 3.  | Have you ever had any operations/procedures involving the use of metal plates, pins, clips, coils, stents, gastric bands, mesh or breast implants? |  |  |  |
| 4. | Have you ever fractured a bone? If yes, please provide details.  |  |  |  |
| 5.  | Have you ever been diagnosed with osteoporosis and if so, have you ever been prescribed any medication associated with this diagnosis?  |  |  |  |
| 6. | Could you be pregnant?  |  |  |  |
| 7.  | Do you have any allergies?  |  |  |  |
| 8.  | Please tick if any of the following apply to you

|  |  |
| --- | --- |
| Currently on or have previously taken steroids |  |
| Currently on or have previously been on HRT |  |
| Menopausal or post-menopausal |  |
| Have undergone a Hysterectomy  |  |
| Polycystic ovaries |  |
| Eating Disorder (anorexia or bulimia) |  |
| Previous Weight loss surgery |  |
| Diabetic |  |
| Currently have cancer or have had a previous cancer diagnosis |  |
| Family history of Osteoporosis  |  |

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| 9.  | Do you have any other chronic medical conditions or is there any other medical information you feel is relevant and would like to provide?      |
| **I take full responsibility for the information given and confirm that it is correct to the best of my knowledge.** |
|  | Patient signature | Authorized person Initials  |  Date |
|  |  |  |  |

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| Additional space for any supporting information.  |
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