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DEXA Bone Density Screening Questionnaire

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 X-ray dye in the last week? YES NO

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

Have you ever had a bone density test? YES NO
 If YES, when and where? _____

Have you had a recent weight change? YES NO
 If YES, tell us about it: _____

Your tallest height (late teens or young adult): _____

Have you ever broken a bone? YES NO

Bone broken	Please describe the circumstances	Age when this occurred

Any family history of osteoporosis? YES NO
 Has a parent or sibling had a broken hip? YES NO
 Have you ever had an eating disorder (Anorexia, Bulimia)? YES NO
 How many times have you fallen in the last year? _____

Have you ever had surgery of the spine, hips, or forearms? YES NO
 If YES, describe what type of surgery you had and which side was affected:

Are you currently receiving or have you previously received prednisone (cortisone) pills? YES NO
 Please list any chronic medical conditions that you have (ie. Hyperparathyroidism, Rheumatoid Arthritis):

Are you currently receiving or have you previously received any of the following medications:

Type of medication:	NO	YES	For how long?
Medication for seizures or epilepsy			
Chemotherapy for any type of cancer			
Medication for prostate cancer			
Medication to prevent organ transplant rejection			
Estrogen inhibitors			

Have you been treated with any of the following medications?

Medication	Ever?	Currently?	If current, how long?
Hormone replacement therapy (Estrogen): Low or normal dose			
Tamoxifen			
Raloxifene (Evista)			
Testosterone			
Etidronate (Didronel/Didrocal)			
Alendronate (Fosamax)			
Risedronate (Actonel)			
Ibandronate (Boniva)			
Intravenous pamidronate (Aredia)			
Clodronate (Bonefos, Ostac)			
Calcitonin (Micalcin nasal spray)			
PTH (Forteo)			
Zoledronic Acid (Zometa, Reclast)			

How many servings of the following do you eat or drink per day (on average)?

Milk (cups) _____ Fruits _____

Orange juice fortified with calcium (cups) _____ Vegetables _____

Yogurt (small container or 1/2 cup serving) _____ Cheese _____

Do you take any calcium supplements (including TUMS)? YES NO

Do you take any Vitamin D supplements (including multivitamins)? YES NO

Do you smoke? Past/Current? YES NO Do you drink 3 or more alcoholic bev. per day? YES NO

Do you exercise? YES NO How many days/week _____

For women only...

Are you still having menstrual periods? YES NO

Before menopause, have you ever missed your periods for 6 months, besides during pregnancy? YES NO

Age at menopause? _____

Have you had a hysterectomy? YES NO

If YES, at what age? _____

Have you had both of your ovaries removed? YES NO

If YES, at what age? _____

By signing below, I attest that the answers I have provided to the questions on this form are true and correct to the best of my knowledge.

Patient or guardian signature

Date