Rockledge MRI & PET Imaging Center
1910 Rockledge Blvd. Suite 102, Rockledge, FL. 32955
321-636-6599

DEXA PATIENT QUESTIONNAIRE

Name:	Today's Date:
Date of Birth:	Sex: Male Female
Weight: (lb.)	Ethnicity:
Patient ID:	Accession #:
Referring Physician:	

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Have you taken any Calcium supplements or Vitamins within the past 24hours? Yes No

(Female only) At what age did you start your menstrual cycle? _____

(Female only) At what age did you stop your menstrual cycle? _____

What is your current height? _____

What was your maximum height? _____

Do you perform weight bearing exercises regularly? Yes No

Do you have a personal history of Osteoporosis? Yes No

Do you have a family history of Osteoporosis? Yes No

Have you had any bone fractures that did not involve direct trauma? Yes No

Do you regularly consume dairy products? Yes No

Do you smoke? Yes No

Do you drink more than 2 alcoholic drinks daily? Yes No

Do you drink caffeinated beverages? Yes No

Have you ever been diagnosed with any type of cancer? Yes No

Have you ever been diagnosed with Rheumatoid Arthritis? Yes No