

DEXA QUESTIONNAIRE/AUTHORIZATION

(office use)

Name: _____ Date of Exam: _____

Date of Birth: _____ Age: _____ Sex: _____ Height: _____ Weight: _____

1. Why are you having this exam?

2. Have you fractured a bone as an adult? Yes No

3. History of hip fracture in mother or father? Yes No

4. Do you consume alcohol (3 or more drinks per day)? Yes No

5. Do you currently use tobacco? Yes No

6. Do you currently take any glucocorticoids?

- ☐ BETAMETHASONE ☐ METHYLPREDNISOLONE
- ☐ BECLOMETHASONE ☐ HYDROCORTISONE
- ☐ TRIAMCINOLONE ☐ DEXAMETHASONE
- ☐ PREDNISONE ☐ CORTISONE BUDESONIDE
- ☐ PREDNISOLONE

7. Do you have a history of Rheumatoid Arthritis? Yes No

8. Do you have any of the following conditions?

- ☐ Type I Diabetes
- ☐ Osteogenesis imperfecta
- ☐ Untreated or long-standing hyperthyroidism
- ☐ Premature menopause (<45 years)
- ☐ Chronic liver disease (cirrhosis)

9. **FEMALE PATIENTS**

Is there any possibility that you are pregnant? Yes No

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If you have any questions, please speak to any staff member and they will contact a physician to answer your questions.

I authorize Weill Cornell Imaging at NewYork-Presbyterian, its physicians and other staff to perform the prescribed examination.

Signature of Patient:
(Parent or Guardian)

Date:

(office use)

Front Desk Staff: _____

Signature: _____

Technologist: _____

Signature: _____

Nurse: _____

Signature: _____