Weill Cornell Imaging

NewYork-Presbyterian Weill Cornell Medicine

T: 212-746-6000 | www.wcinyp.com | F: 646-962-0122

(office use)

DEXA QUESTIONNAIRE/AUTHORIZATION

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

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: _____

The Patients' Bill of Rights is available for your review.

(office use)

Front Desk Staff:_____ Signature: _____

Technologist:_____ Signature: _____

Nurse:_____ Signature: _____