**DXA Health History Questionnaire**

1. First Name \_ \_ \_ \_ \_ \_ \_\_ \_ \_ \_ \_ \_ \_ \_ \_ \_ Last name \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_
2. Date of Birth \_ \_ / \_ \_ \_ / \_ \_ \_ \_ Email address \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_
3. Please tick any conditions you have in this list:

☐ Over active thyroid

☐ Over active parathyroid

☐ Long term kidney disease

☐ Long term liver disease

☐ Rheumatoid arthritis

☐ Osteo-arthritis

☐ Osteogenesis imperfecta

☐ Long term Cortisone Therapy (eg Asthma inhaler for >3 months at present)

☐ Bowel Disease (eg malabsorption, Crohn’s disease, Coeliac disease, short bowel)

☐ Insulin dependent diabetes

1. Have either of your parents had a hip fracture? No / Yes

Have you ever broken/fractured a bone (as an adult)? No / Yes In car accident? ☐

If YES which bone(s) & when (year)? . . . . . . . . . . . . . .. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

1. Have you had any operations on your bones (including replacements)? No / Yes

If YES which bone(s) & when (year)? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

1. Have you had X-ray/CT or Nuclear Medicine images in the last 1-2 weeks? No / Yes

If YES what test & when (day)? ……………………………………………………. . . . . . . . . . .

1. Have you previously had a bone density test? No / Yes

If YES when and where? ……………………………………………………. . . . . . . . . . .

1. Please list any current medications:

…………………………………………………………………………………………. . . . . . . . . . .

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1. Menopause information - Adult females only

Are you still menstruating regularly? No / Yes If not menstruating, when was your last period? \_ \_ \_ \_ \_ \_ \_

Have you had a hysterectomy? No / Yes \_ \_ Age at hysterectomy? \_ \_ \_ \_ \_ \_

Have you had your ovaries removed? Don’t know ☐ No / Yes

10. Pregnancy – Is there a chance you could be pregnant? No / Yes (We have pregnancy testing kit if unsure)

11. How did you hear about us?

…………………………………………………………………………………………. . . . . . . . . . .

12. Your General Practitioner’s Name & Practice

…………………………………………………………………………………………. . . . . . . . . . .

Signed ……..………………….Date \_ \_ / \_ \_ / \_ \_ \_ \_

Reviewed by ………………………Signed ……..………………….