

Bone Density DXA Scan Risk Assessment

Name (print): _____ Date of birth: _____ Date: _____

Have you had a barium X-ray or contrast injection in the last 2 weeks?Yes No

Which doctor ordered your DXA scan? Shaw...Chatterji...Heath...Louie.. .other _____

Would you like another doctor to have a copy of this report? If yes, name _____

1. **Have you ever had a bone density test?.....No If Yes...when & where** _____

What was the result? Normal Osteopenia Osteoporosis

2. **Have you ever had surgery to your hip, spine or wrist?.....** Yes No

3. **Have you ever broken/fractured a bone as an adult (age 40 or over)?**Yes No

Which bone?	How did it happen?	At what age?

4. **Has either of your parents suffered a hip fracture?** Yes No

Is there family history of osteoporosis? No ___ Yes ___ Relationship _____

5. **Do you currently smoke tobacco?**Yes No

Did you ever smoke tobacco.....Yes....No Number of years ___ Year you quit? _____

6. **Do you drink (3+ alcoholic) beverages per day?.....**Yes No

7. **How many cups of caffeinated beverages do you drink daily?.....** ___ cups

8. **Have you been diagnosed with arthritis? Yes No Osteo Rheumatoid Psoriatic**

9. **Have you ever taken oral steroids (prednisone) for 3 months or more?**Yes No

If yes, what is the dose _____ How long? _____ Reason _____

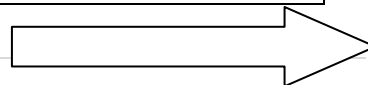
Have you ever used inhaled steroids?Yes....No

10. **Have you had any of the following conditions?**

	No	Yes	How long?	
Liver disease				
Kidney disease				
Kidney stones & type (if known)				Calcium Uric acid Not known
Gastric bypass (for weight loss)				
Hyperthyroid (over active)				
Hypothyroid (under active)				
Thyroid removed				
Taking thyroid medication (synthroid) Levothyroxine				
Hyperparathyroidism				
Parathyroid removed				
Eating disorder (anorexia/bulimia)				
Cancer (type) & treatment				Radiation Chemotherapy
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11. **Are you currently or previously taken any of the following medications?**

Medication type	No	Yes	For how long?
Medication for prostate cancer or breast cancer			
Medication to prevent organ transplant rejection			
Lithium (Bipolar disorder)			
Water/fluid pills (HCTZ, Lasix, furosemide, Bumex, etc)			
Acid Reflux, GERD, heartburn, Acid blockers,			
Medication for seizures or epilepsy			



CARROLL ARTHRITIS, P.A.

12. Have you ever taken or are currently taking any of these medications for your bones?

Medication	No	Yes	Now	How Long?	Date stopped	Issues	Groin pain
Alendronate Fosamax Fosamax +D							
Actonel Atelvia							
Boniva pills or Boniva IV							
Reclast (IV)							
PTH (Forteo)							
Miacalcin or Fortical nasal spray							
Evista							
Prolia							
Zoledronic acid (Zometa)							

13. On a daily basis, how many servings of dairy products, broccoli, kale, spinach, almonds, other
None 1 2 3 4 5

14. Do you take any of the following? Check the box; name the brand if you know it

	Yes	No	mg /pill	IU per pill	# pills	Brand	
Calcium (no added D ³)							
Calcium + D ³							
Multivitamin with calcium							
Vitamin D ³							
Prescription vitamin D ² 50,000 IU Weekly/Monthly							

15. Have you ever had a Vitamin D blood test? Yes ___ No ___ If Yes: by whom? _____
Were you deficient? Yes ___ No ___ Were you given a prescription? Yes ___ No ___

16. Do you do any weight bearing exercise like walking?Yes No
How many times per week? _____ For how long? _____

17. Do you do any strengthening exercises: Weights, Tai Chi, Yoga, resistance bands? Yes No

18. Have you had any falls in the past 3 months? Yes No
If yes, how many times _____ How did you fall? _____ Injury _____ Yes No
_____ How did you fall? _____ Injury _____ Yes No
Did you go to the Emergency Room? Yes ___ No ___ Beak a any bones? Yes ___ No ___

For women only

- Is there any chance you could be pregnant?.....Yes No
- Have you had a hysterectomy?Yes at age? ___ No
- Have you had your ovaries removed?.....Yes at age? ___ No
- **Do** you take estrogen or progesterone?.....Yes - Name _____ No
- **Did** you ever take estrogen or progesterone after menopause? Yes ___ No ___
- Have you gone through menopause?Yes No
- **If yes, how old were you? _____ If no, date of last menstrual cycle _____**

Office use only below this line

Name: _____ PT ID _____ LVA _____ FRAX _____
 Weight _____ Changes? _____ Reason _____
 Tallest height _____ Cal dietary _____ vit D dietary _____ Prior DXA _____
 Current height _____ Cal pills _____ vit D pills _____ dx _____
Change _____ **Total** _____ **Total** _____ **50,000IU weekly monthly**
DXA only **DXA/OV** **DXA Infusion** **DXA /BW** **DXA/Prolia** **DXA/Boniva**

BHE given to patient Y N Refused Retraction Balance PT Technical