CARROLL ARTHRITIS, P.A.

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
Cancer (type) & treatment				Radiation Chemotherapy

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			

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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