

**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 \_\_\_\_\_

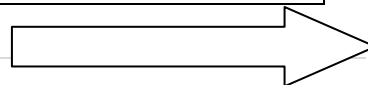
Have you ever used inhaled steroids? ....Yes....No

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 <sup>3</sup> )							
Calcium + D <sup>3</sup>							
Multivitamin with calcium							
Vitamin D <sup>3</sup>							
Prescription vitamin D <sup>2</sup> 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