

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

- Have you had any barium X-ray or contrast injection in the last 2 weeks: Yes ___ No ___
- Which doctor ordered your DXA scan? Heath ___ Esfahani ___ other _____
- Would you like another doctor to have a copy of this report? Yes ___ No ___
If yes: Name _____ & FAX # (required) _____

1. **Have you ever had a DXA Scan?** Yes ___ No ___
If yes: when and 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? Yes ___ No ___ In whom? _____

5. **Do you currently smoke tobacco?** Yes ___ No ___ Did you ever smoke tobacco? Yes ___ No ___

6. **Do you drink (3+ alcoholic) beverages per day?** Yes ___ No ___ If yes, what kind: _____

7. **Do you drink 3 or more servings of caffeine daily?** Yes ___ No ___

8. **Have you been diagnosed with arthritis?** Yes ___ No ___ If yes, what kind: Osteo Rheumatoid Psoriatic

9. **Have you ever taken steroids (prednisone) for a long period of time?** 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 | If yes, how long? |
|--|----|-----|---------------------------|
| Liver disease | | | |
| Kidney disease | | | |
| Kidney stones + type (if known) | | | Calcium Uric Acid Unknown |
| Gastric bypass (for weight loss) | | | |
| Hyperthyroid (over active) | | | |
| Hypothyroid (under active) | | | |
| Thyroid removed | | | |
| Taking thyroid medication Synthroid Levothyrocin | | | |
| Hyperparathyroidism | | | |
| Parathyroid removed | | | |
| Eating disorder (anorexia/bulimia) | | | Current or Prior |
| Cancer (type) & treatment | | | Radiation Chemotherapy |
| Cancer (type) & treatment | | | Radiation Chemotherapy |

| Medication | No | Yes | For how long? |
|--|----|-----|---------------|
| Medication for prostate cancer or breast cancer | | | |
| Medication to prevent organ transplant rejection | | | |
| Lithium | | | |
| Water pills HCTZ, Lasix, furosemide, Bumex | | | |
| Acid reflux, GERD, heartburn, acid blockers | | | |
| Medication that is commonly used for seizures | | | |

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

11. How many servings of the following do you eat/drink per day (on average)? None

Cow/other milk _____ Cheeses _____ Yogurt _____ Fortified OJ _____ Almonds _____ Green leafy _____

12. Do you take any of the following?

| | No | Yes | Milligrams of calcium | # of pills | IU vit D or mcg |
|--------------------------------------|----|-----|-----------------------|------------|-----------------|
| Calcium (no vit D3) | | | | | |
| Calcium + D3 | | | | | |
| Multivitamin with calcium | | | | | |
| Vitamin D3 | | | | | |
| Prescription vitamin D2 50,000 IU | | | | | |

13. Have you ever been diagnosed with vitamin D deficiency? Yes ___ No ___

If yes, by whom? _____

Were you treated with a prescription Vitamin D (50,000 IU)? Yes ___ No ___

14. Are you doing any weight bearing exercise like walking? Yes ___ No ___

How many times per week? _____ How long? _____

15. Are you doing any strengthening exercise: Weights, Tai Chi, Yoga, resistance bands? Yes ___ No ___

16. Have you had any falls in the past year? Yes ___ No ___ If yes, how many times _____

How did you fall? _____ Injury _____

Did you go to the Emergency Room? Yes ___ No ___ Break any bones? Yes ___ No ___

For women only (please circle yes/no)

- Is there any chance you could be pregnant? Yes No
 - Have you had a hysterectomy? Yes No
 - Did you have your ovaries removed? Yes No
 - Do you take estrogen or progesterone? Yes No
 - Did you ever take estrogen or progesterone? Yes No
 - Have you gone through menopause? Yes No
- If yes, at what age? _____ If no, when was your last menstrual cycle _____

Office use only below this line

Name: _____ PT ID _____ LVA _____ FRAX _____

Weight: _____ Changes? _____ Reason _____

Tallest height _____ Current Height _____