Patient Email: _____

I agree to receive DXA reports via email.

PATIENT NAME _____Date of Birth: _____

Height: _____ Weight: _____lbs. Are you pregnant? Yes No

Right handed? ___ Left Handed?___ Have you had a hysterectomy? Yes No Partial

Post-menopausal _____ Appx. Menopause Age:_____

Are you on hormone replacement therapy (HRT)? Yes No Patch

Have you been diagnosed with osteopenia or osteoporosis? Yes No

Any Family history of OSTEOPOROSIS? Yes No If yes, who? _____

Any Hip/Spine surgeries with metal or pins? Yes No Location _____

Have you had a Nuclear Exam in the **LAST 5 DAYS** injected with contrast medium? Yes No

Medications Currently Used:

_____ Actonel
_____ Boniva
_____ Fosamax
_____ Other Prescribed Bone Meds
_____ Evista (Raloxifene)
_____ Forteo/Reclast
_____ Thyroid Meds

History of treatments:

_____ Chemotherapy Treatment
_____ Tamoxifen (Nolvadex)
_____ Steroids/Prednisone/cortisone-like meds
_____ Miacalcin (Calcitonin)

CURRENTLY EXERCISES: Average Times per Week: _____ NONE_____

DAILY: Vitamin D Pills? Yes or No Calcium Pills? Yes or No Multi-Vit? Yes or No

FRAX 10-year Calculation Report (Fracture Risk Assessment):

Alcohol - do you consume (on average) 2 or more drinks daily?	Yes	No
Biological mother or father with history of a hip fracture?	Yes	No
Use of steroids (3 or more months of prednisone or equivalent meds)?	Yes	No
Previous history of adult fracture? Spontaneous? Trauma?	Yes	No
Type 1 Diabetes, Premature Meno, Osteogenesis, Chronic Malabsorption?	Yes	No
Confirmed diagnosis of Rheumatoid Arthritis (RA)?	Yes	No
Current Smoker	Yes	No

Study Population for FRAX Report that best relates to you:

Asian _____ Black _____ Caucasian _____ Hispanic _____Other _____

SIGNATURE _____Today's Date: _____

Tech Notes:

HEIGHT:

WEIGHT:

Tech: _____

Pt. Rev: ____

Syn: _____

FAX: _____

CC: _____

MD: _____