Patient Email: ____

I agree to receive DXA reports via email.

PATIENT NAME ____Date of Birth: ______________________

Height: ___________ Weight: ____________lbs. Are you pregnant? Yes No

Are you right handed?__________________ Left handed?____________________

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:		History of treatments:
_____ Actonel	______ Evista (Raloxifene)	______ Chemotherapy Treatment
_____ Boniva	______ Forteo/Reclast	______ Tamoxifen (Nolvadex)
_____ Fosamax	______ Thyroid Meds	______ Steroids/Prednisone/cortisone-like meds
_____ Other Prescribed Bone 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: ______