

Print Name: _____ Date: _____ Age: _____
 Birth date: _____ Height: _____ Weight: _____ Are you right or left handed? Right Left
 Ethnicity: Caucasian African-American Hispanic Asian
 Previous DXA scan? Yes No If yes, When: _____ Where: _____

PLEASE CHECK ANY OF THE FOLLOWING MEDICATIONS YOU ARE CURRENTLY TAKING:

- | | | |
|---|---|--|
| <input type="checkbox"/> ACTONEL (Risedronate) | <input type="checkbox"/> EVISTA (Raloxifene) | <input type="checkbox"/> PROLIA (Denosumab) |
| <input type="checkbox"/> AREDIA (Intravenous Pamidronate) | <input type="checkbox"/> FORTEO or PTH (Teriparatide) | <input type="checkbox"/> RECLAST (Intravenous Zoledronic acid) |
| <input type="checkbox"/> ARIMIDEX (Anastrozole) | <input type="checkbox"/> FOSAMAX (Alendronate) | |
| <input type="checkbox"/> BONIVA (Ibandronate) | <input type="checkbox"/> MIACALCIN (Calcitonin) | |
| <input type="checkbox"/> OTHER (Bone Density Medications Only) _____ | | |
| <input type="checkbox"/> STEROID MEDICATION (name, strength (mg), length of time (months/years) _____ | | |

PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING:

- | | | |
|--|-------------|-----------------|
| <input type="checkbox"/> Spinal Fracture | Date: _____ | Describe: _____ |
| <input type="checkbox"/> Spinal Surgery | Date: _____ | Describe: _____ |
| <input type="checkbox"/> Hip Fracture | Date: _____ | Describe: _____ |
| <input type="checkbox"/> Hip Surgery | Date: _____ | Describe: _____ |

FEMALE PATIENTS ONLY:

- Pregnant or possibly pregnant? Yes No
- Premenopausal, last menstrual period _____ Hysterectomy Date: _____
- Current menopausal symptoms _____ Ovaries removed? None One Both
- Postmenopausal, age of onset _____

_____	_____	_____	_____	_____
Patient/Legally Authorized Person Signature	Printed Name	Title (Self, Nurse, Caregiver, etc.)	Date	Time

<input type="checkbox"/> Phone OR <input type="checkbox"/> Video				
_____	_____	_____	_____	_____
Qualified Staff / Interpreter Signature	Print Qualified Staff / Interpreter Name	ID Number	Language Interpreted	

Technologist only below this line:

- FRAX (Ask patient the following questions, check boxes that apply)
 (Age 40 - 90)
- Have you had a spontaneous fracture between ages 40-90? Describe: _____
- Has your mom or dad had a fractured hip?
- Are you a current smoker?
- Do you drink 3 or more alcoholic beverages per day?
- Do you have Rheumatoid Arthritis?
- Have you taken oral steroids (5mg) for 3 consecutive months any time in your life?
- Secondary Osteoporosis:
- Do you have Diabetes Type I (insulin dependent)?
- Do you have Hyperthyroidism?
- Do you a chronic liver disease?
- Do you have Crohn's disease or other malabsorption conditions?
- Did you start menopause before age 45?
- | | | |
|--|--|---|
| <input type="checkbox"/> BASELINE DXA | <input type="checkbox"/> FOLLOW-UP DXA (Comparison Included) | <input type="checkbox"/> PERIMENOPAUSAL |
| <input type="checkbox"/> FIRST DXA AT FH | <input type="checkbox"/> PREMENOPAUSAL | <input type="checkbox"/> POSTMENOPAUSAL |

_____	_____	_____	_____	Patient Label or MRN _____
Technologist Authentication	OPID	Date	Time	