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Jenna Brewer, PA-C ✦ **Tera Puckett, PA-C** ✦ **Karis Paisley, FNP-C** ✦ **Jennifer Crumm, PA-C**

Dear Patient:

A bone density test uses X-rays to measure how many grams of calcium and other bone minerals are packed into a segment of bone. A bone density test is a fairly accurate predictor of your risk of fracture.

To get the best results possible, please follow these instructions:

Unless instructed otherwise, eat normally on the day of the exam, but avoid taking calcium supplements for at least 24 hours prior to your appointment.

Wear loose, comfortable clothing. Sweat suits and other casual attire without zippers, buttons, or any metal are preferred.

You should not have had a barium study, radioisotope injection, oral or intravenous contrast material from a CT scan or MRI within seven days prior to your DEXA test.

Please answer the questionnaire to the best of your ability and return this on the day of the test.

Please arrive 15 minutes before your scheduled examination.

Please fill out the form to the best of your ability. This will help us assess your overall fracture risk.

Patient Name: _____ Date of Birth: _____

Age: _____ Gender: M / F Physician: Bajaj / Lackan / Tan / Hudak

Weight: _____ lbs. Height: _____ ft. _____ in.

Ethnic Background:

Caucasian / African American / Asian / Hispanic /

Other, please specify: _____



Patient Name: _____

1. Have you had any previous:		Yes	No	
Hip Fractures? If so, which hip? R / L		<input type="checkbox"/>	<input type="checkbox"/>	
Spine/vertebral fractures?		<input type="checkbox"/>	<input type="checkbox"/>	
Wrist fractures? If so, which arm? R / L		<input type="checkbox"/>	<input type="checkbox"/>	
2. Are you currently taking or have taken osteoporosis medication? (see below)				
Drug	Currently Taking	How long have you been on it?	Previously Taken	How long did you take it?
Fosamax (alendronate)	<input type="checkbox"/>		<input type="checkbox"/>	
Actonel (risedronate)	<input type="checkbox"/>		<input type="checkbox"/>	
Boniva (risedronate)	<input type="checkbox"/>		<input type="checkbox"/>	
Reclast (zoledronate)	<input type="checkbox"/>		<input type="checkbox"/>	
Miacalcin (miacalcin)	<input type="checkbox"/>		<input type="checkbox"/>	
Evista (raloxifene)	<input type="checkbox"/>		<input type="checkbox"/>	
Forteo (teriparatide)	<input type="checkbox"/>		<input type="checkbox"/>	
Prolia (denosumab)	<input type="checkbox"/>		<input type="checkbox"/>	
			<u>Yes</u>	<u>No</u>
3. Are you pre-menopausal?		<input type="checkbox"/>	<input type="checkbox"/>	
4. Did your mother or father ever have a hip or spine fracture?		<input type="checkbox"/>	<input type="checkbox"/>	
5. Do you currently smoke?		<input type="checkbox"/>	<input type="checkbox"/>	
6. Do you currently take oral steroids, or have you ever been on oral steroid longer than 3 months? If so, name and dose of steroid: _____ How long have you taken them? _____		<input type="checkbox"/>	<input type="checkbox"/>	
7. Do you have a confirmed diagnosis of rheumatoid arthritis?		<input type="checkbox"/>	<input type="checkbox"/>	
8. Do you have one of the following disorders that are associated with secondary osteoporosis? If so, please circle: Type 1 Diabetes Asthma or Emphysema Untreated hyperthyroidism Seizure disorder Hypogonadism (low testosterone) End Stage Kidney Disease Premature menopause (age < 45) Anorexia Hyperparathyroidism GI disease (malabsorption) Cholesteric liver disease		<input type="checkbox"/>	<input type="checkbox"/>	
9. Do you drink 3 or more alcoholic drinks per day? 1 drink = 1.5 oz. liquor, 10 oz. beer, 4 oz. wine		<input type="checkbox"/>	<input type="checkbox"/>	



Waiver of Liability

Diabetes and Thyroid Center of Fort Worth (DTC) will make every attempt to have the DEXA scan reimbursed by your insurance company. In the event that the DEXA scan is considered 'not payable' by the insurance company, we will have to bill the patient for the DEXA scan. By signing this form, the patient or responsible party agrees to pay DTC for the DEXA scan in the event that the insurance company refuses payment.

Patient/ Responsible Party Signature: _____

Date: _____

