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Patient Risk Assessment

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Have you had a previous DXA scan?  Yes  No

If yes, where? \_\_\_\_\_ Date of scan: \_\_\_\_\_

Referred by: \_\_\_\_\_

Sent copies of DXA report to the following medical professionals: \_\_\_\_\_  
\_\_\_\_\_

Height \_\_\_\_\_ ft. \_\_\_\_\_ in.

Weight \_\_\_\_\_ lbs. Family history of osteoporosis?  Yes  No

Fracture:  Spine  Hip  
 Wrist  Other: \_\_\_\_\_

Previous Surgery:  Transplant Date: \_\_\_\_\_  Hip Date: \_\_\_\_\_  
 Bariatric Date: \_\_\_\_\_  Spine Date: \_\_\_\_\_

Smoking \_\_\_\_\_

Alcohol \_\_\_\_\_

Steroid therapy \_\_\_\_\_

Meds \_\_\_\_\_

Vitamins \_\_\_\_\_

Calcium \_\_\_\_\_ mg Type \_\_\_\_\_

Milk Drinker?  Yes  No  Not much

Dairy?  Yes  No Lactose intolerant?  Yes  No

Physical activity: \_\_\_\_\_

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**For Women:**

Age at menopause (or surgical) \_\_\_\_\_

Is there a possibility of pregnancy?  Yes  No

Hormone therapy?  Yes  No Type \_\_\_\_\_