OSTEOSCAN PARTNERS IN FRACTURE PREVENTION

QUESTIONNAIRE

NAME …… DATE OF BIRTH ……

EMAIL ADDRESS …… ☐ No email address

Do you object to being contacted about participation in research? ☐ *Yes* ☐ *No*

When was your last Bone Density test?	Last test was _____ ☐ I haven't had a Bone Density test before
***Please Note**: If it has been **less than 2 years** since your previous scan under Medicare then you will not be eligible for a Medicare rebate and **full payment of the account** will apply. Prior to 1st November 2017 all 70 year olds were entitled to a Medicare rebate. The government has amended this arrangement and entitlement to the Medicare rebate for over 70 year olds will not be guaranteed. All patients 70 years and over are eligible for an Initial Scan **but a gap payment will apply if you are not a concession card holder.** Patients who are recalled for a repeat scan will need to check whether they are entitled to a Medicare rebate.*	
Which of the following bones have you broken as a result of a simple trip or fall since turning 50. **(*Do not include broken bones resulting from trauma or vehicle accidents)***	☐ I haven't broken any bones ☐ Rib(s) ☐ Wrist or arm ☐ Leg ☐ Hip(s) ☐ Ankle(s) ☐ other _____ ☐ Spine / vertebra (No. of broken vertebrae _____)
Have you had a hip replacement?	☐ No - I have not had a hip replacement ☐ Yes - Left ☐ Yes – Right
Have you had a fall in the last 12 months?	☐ I have not fallen in the last 12 months ☐ I have had _____ fall(s) in the last 12 months
Can you get up from a chair with your arms folded?	☐ Yes ☐ No
Do you take sleeping tablets?	☐ Yes ☐ No
Do you smoke cigarettes?	☐ Yes ☐ No
On average, how many alcoholic drinks would you consume?	☐ I don't drink alcohol ☐ per day _____ ☐ I occasionally drink ☐ per week _____
Does not apply to males **Did you experience menopause before age 45?**	☐ Yes ☐ No ☐ Not yet 45 years old
Do you take Calcium or Vitamin D supplements?	☐ Calcium ☐ Vitamin D ☐ No supplements
Laminated medication card is located on the reception desk **Which of the medications listed on the medication card do you take?**	☐ None _____
Please indicate if you suffer from any of the following conditions -> **Tick only the ones that apply**	☐ Overactive thyroid ☐ Overactive parathyroid (different from "thyroid") ☐ Coeliac disease ☐ Crohn's disease ☐ An eating disorder (anorexia or unusual diets) ☐ Rheumatoid Arthritis (different from Osteoarthritis) ☐ Kidney disease ("renal disease") ☐ Liver disease ☐ High Prolactin levels / Pituitary disorder ☐ Male hormone deficiency