OSTEOSCAN PARTNERS IN FRACTURE PREVENTION

Personal details

Gender: M / F / Other **Title**: Mr Mrs Ms Miss Dr Other: **DOB:** _____

First name: _____ **Middle Initial:**_____ **Last name**: _____

Email address: _____ **No email:** □

Medical details

For the following questions, please tick (✓) the box if the answer applies to you.

1. **Have you had a bone density scan elsewhere in the last 5 years? (Ignore if done at Osteoscan)**
   - ☐ No/I've never had a bone density scan.
   - ☐ Yes. Date:_____ ____

2. **Since turning 50, which of the following bones have you broken as a result of a simple trip or fall?** *(Do not include broken bones resulting from trauma or vehicle accidents)*
   - ☐ None/not yet 50 years old
   - ☐ Rib(s)
   - ☐ Wrist or arm
   - ☐ Leg
   - ☐ Hip(s)
   - ☐ Ankle (s)
   - ☐ Spine/vertebra; if so how many? ____
   - ☐ Other, please specify: _____

3. **Have you had a hip replacement?**
   ☐ No ☐ Left hip ☐ Right hip

4. **How many falls have you had in the past 12 months?**
   - ☐ No falls ☐ 1 fall ☐ 2 falls
   - ☐ 3 or more falls; please specify how many: ___

5. **Can you get up from a chair with your arms folded?**
   ☐ Yes ☐ No

6. **Do you take sleeping tablets?**
   ☐ Yes ☐ No

7. **Do you smoke cigarettes?**
   ☐ Yes ☐ No

8. **On average, how many alcoholic beverages would you consume?** *(Please select one)*
   - ☐ Per day; please specify how many: _____
   - ☐ Per week, please specify how many: _____
   - ☐ Occasionally ☐ I do not drink alcohol

9. **Did you experience menopause before the age of 45?** *(Only applies to females. Includes hysterectomies)*
   ☐ Yes ☐ No ☐ I am not yet 45

10. **Do you take any of the following supplements?**
    ☐ Calcium ☐ Vitamin D ☐ Neither

11. **Please indicate if you have any of the following conditions:**
    - ☐ None
    - ☐ Overactive thyroid
    - ☐ Coeliac disease (diagnosed Coeliac only)
    - ☐ Crohn's disease
    - ☐ Rheumatoid Arthritis (not Osteoarthritis)
    - ☐ Overactive parathyroid (different from thyroid)
    - ☐ Kidney disease ("renal disease")
    - ☐ Liver disease
    - ☐ Eating disorder (anorexia or unusual diets)
    - ☐ High prolactin levels/pituitary disorder
    - ☐ Male hormone (androgen) deficiency

12. **Which of the medications do you take?** *(Please refer to the laminated medication card which is attached to the clip-board)* ☐ None

_____

_____

STAFF ONLY ***XLAPS____*VFA____*FRAX____**

***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.*