

Osteoporosis Screening Questionnaire

Name: _____
 Date of Birth: _____

Date: _____
 Age: _____
 Race: W / B / Asian / Hispanic
 Wt: _____
 Ht: _____

1. Do you have a family history of osteoporosis? Yes No
 Mother Sister(s) Other (Specify) _____
2. Have you ever had breast cancer? Yes No
 If so, did you receive Nolvadex (Tamoxifen)? Yes No
3. Have you had any fractures? Hip Spine (Vertebrae) Wrist Other _____
 If yes, when? _____
 Has mother or father had hip fracture: Yes No
4. Have you ever had back surgery? Yes No
 Have you ever had hip surgery? Yes No Right or Left - Both
5. I have never smoked. I used to smoke. I still smoke.
 For past and current smokers: _____ packs per day for _____ years.
6. Do you drink alcohol? _____ If yes, daily alcohol intake _____
7. Have you ever taken, or are you currently taking any of the following?

	Past	Present	For how long?
Calcium	<input type="checkbox"/>	<input type="checkbox"/>	_____
Calcitonin (Miacalcin) Nasal Spray/Injections	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fosamax (alendronate)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Actonel (Risedronate)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Prednisone, Cortisone or other steroid	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Replacement	<input type="checkbox"/>	<input type="checkbox"/>	_____
Evista (raloxifene)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dilantin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Forteo (PTH)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Boniva (Ibandronate)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Reclast or Zometa (Zoledronic acid)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Prolia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Evenity	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tymlos	<input type="checkbox"/>	<input type="checkbox"/>	_____
Xgeva	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vit D	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. Do you exercise regularly, the equivalent of a three mile walk three times a week? Yes No
 How much weight-bearing exercise do you do (walking, cycling, jogging, aerobics)? _____
9. Do you eat a diet with three or more dairy servings per day? Yes No
10. **For Women Only:**
 Are you still having menstrual periods? Yes No
 If no, when did your periods end? _____
 Have you ever had a hysterectomy? Yes No
 If so, what year? _____
 Were your ovaries removed? Yes No
 Have you ever taken female hormones? (Estrogen / Premarin / Ogen / Estratest, etc.) Yes No
 If yes, when and for how long? _____
 Are you taking female hormones now? Yes No
11. **For Men Only:**
 Have you ever taken Lupron for prostate cancer? Yes No

**Rheumatology Associates Of
North Alabama, P.C.**

4606 Bellewood Dr. SE
Huntsville, Alabama 35802

Date: _____

INITIALS	OFFICE USE ONLY
ACCOUNT NO.	

PATIENT'S NAME IN FULL (NO NICKNAMES) Last Name First					MARITAL		DATE OF BIRTH	AGE	SEX
					S	M	W	D	SEP
RACE: <input type="checkbox"/> AFRICAN AMERICAN <input type="checkbox"/> ASIAN <input type="checkbox"/> CAUCASIAN / WHITE <input type="checkbox"/> NATIVE HAWAIIAN / OTHER PACIFIC ISLANDER <input type="checkbox"/> AMERICAN INDIAN / ALASKA NATIVE <input type="checkbox"/> DECLINED <input type="checkbox"/> UNKNOWN									
PRIMARY LANGUAGE:					ETHNICITY:				
<input type="checkbox"/> ENGLISH <input type="checkbox"/> SPANISH <input type="checkbox"/> OTHER _____					<input type="checkbox"/> HISPANIC <input type="checkbox"/> NON-HISPANIC <input type="checkbox"/> DECLINED <input type="checkbox"/> UNKNOWN				
ADDRESS					CITY, STATE & ZIP				
SOCIAL SECURITY NO.			CELL NO. ()		HOME NO. ()		EMAIL		
OCCUPATION (INDICATE IF STUDENT)			EMPLOYER		HOW LONG EMPLOYED?		RELIGION (OPTIONAL)		
EMPLOYERS ADDRESS					CITY, STATE & ZIP				
HUSBAND, WIFE, PARENT OR GUARDIAN NAME					DATE OF BIRTH		SSN		
EMPLOYER OF ABOVE NAME			CITY & STATE		ZIP CODE		BUSINESS PHONE NO. ()		
PERSON TO NOTIFY IN CASE OF EMERGENCY OTHER THAN SPOUSE			RELATIONSHIP		CELL NO. ()		HOME NO. ()		
ADDRESS					CITY, STATE & ZIP				

REFERRING PHYSICIAN				
ADDRESS		CITY & STATE	ZIP CODE	PHONE ()
FAMILY PHYSICIAN				
ADDRESS		CITY & STATE	ZIP CODE	PHONE ()

PERSON RESPONSIBLE FOR BILL: _____
IF OTHER THAN PARENT, S.S.# _____
ADDRESS OF RESPONSIBLE PARTY _____

PRIMARY INSURANCE CO.	NAME OF POLICY HOLDER	POLICY HOLDER DOB	COPAY
CONTRACT NUMBER	GROUP NUMBER	EMPLOYED BY:	
SECONDARY INSURANCE CO.	NAME OF POLICY HOLDER	POLICY HOLDER DOB	COPAY
CONTRACT NUMBER	GROUP NUMBER	EMPLOYED BY:	
OTHER INSURANCE	NAME OF POLICY HOLDER	POLICY HOLDER DOB	COPAY
CONTRACT NUMBER	GROUP NUMBER	EMPLOYED BY:	

AUTHORIZATION FOR SERVICES

The signature below serves as authorization for services rendered by Rheumatology Associates of North Alabama, P.C. for the above named patient, and release of information necessary to file insurance; and assign benefits otherwise payable to policy holder to the doctor or group indicated on the claim. I understand I am financially responsible for any balance not covered by the insurance carrier - a copy of the signature is as valid as the original. Authorization is continuing while patient is under care of Rheumatology Associates of North AL, P.C. or until patient revokes authorization. **For Medicare patients only - Medicare will not pay on the following: Schirmer Test and calcitonin injections.**

AUTHORIZATION FOR RELEASE OF INFORMATION

The signature below serves as authorization for Rheumatology Associates of North Alabama, P.C. to release or receive medical information for the purpose of patient referral. A copy of this signature is as valid as the original. Authorization is continuing while patient is under care of Rheumatology Associates of North Alabama, P.C. or until patient revokes authorization.

Signature: _____ Date: _____

SERVICES CAN BE CHARGED TO YOU THROUGH MASTERCARD, VISA OR DISCOVER