ARTHRITIS
AND
RHEUMATISM
ASSOCIATES, P.C.

Arise Infusion Therapy Services
Arthritis and Rehabilitation Therapy Services
Gout Center of Excellence
Medical Cannabis Institute
Wellness and Weight Loss Center

DIVISIONS OF ARTHRITIS AND RHEUMATISM ASSOCIATES, P.C

Dear Patient:

Enclosed you will find forms relating to our financial policy, patient registration and insurance information and a medical history form which includes a place to list your medications. Please complete the forms in advance and bring them with you to your appointment. Feel free to call our office with any questions.

In addition, remember to:

- Bring your insurance card(s) and a referral form and co-payment, if required by your insurance plan. Also, please bring your doctor's prescription.
  Wear something that does not have metal buttons, zippers or hooks around the waist and hip area. Bra hooks are okay.
- Avoid taking medication that contains calcium (i.e.: calcium supplements, multivitamins, Tums, etc.). You may take all other medications, including osteoporosis drugs like Fosamax, Miacalcin, Actonel, Evista, etc.
- Allow at least a two week interval following any previous x-ray study involving contrast (like barium).
- Arrive with your forms completed!
- There is a weight limit to our DEXA table. If your weight exceeds 350 pounds, it is possible that only a single scan (of the distal forearm) can be performed.

If you have any questions, please do not hesitate to call before your appointment date.

We look forward to seeing you!

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DEXA Medical History

Name: (Last, First, MI): _____ **Date of Birth:** _____

Date of Service: _____ **(Office Use Only) Medical Record #:** _____

Please Answer the Following Questions

Race: ○ Caucasian ○ Asian ○ Hispanic ○ Black

Sex: ○ Female ○ Male Ordering Physician: _____

Have you ever had a bone density test before? ……	○Yes	○No
If yes, when? _____ Where? _____		
Have you fractured any bones after the age of 18? ……	○ Yes	○ No
If yes, what? _____ When? _____		
Did your Mother or Father ever have a hip fracture (s) before the age of 85? ……	○ Yes	○ No
Do you currently smoke? ……	○ Yes	○ No
Do you consume three or more alcoholic beverages daily? ……	○ Yes	○ No
Do you have a family history of osteoporosis?.....	○ Yes	○ No

Women Only:

Are you Post Menopausal?..... ○ Yes ○ No Age at Menopause? _____		
Are you currently on Hormone Replacement Therapy? (HRT/ERT)? ……	○ Yes	○ No
Have you ever taken Provera (Depo-Provera)?.....○ Yes ○ No If Yes, How long? _____		
If you are Premenopausal, when was your last menstrual period? _____		
Are you currently on Birth Control Pills?..... ○ Yes ○ No Are you currently Pregnant?....	○ Yes	○ No

Men Only:

Hypogonadism (Low Testosterone) ……	○ Yes	○ No
Lupron Depot ……	○ Yes	○ No

Have you ever been diagnosed with any of the following conditions?

Hyperparathyroidism ……	○ Yes	○ No	Rheumatoid Arthritis ……	○ Yes	○ No
Lupus ……	○ Yes	○ No	Ankylosing Spondylitis ……	○ Yes	○ No
Paget's Disease ……	○ Yes	○ No	Liver Disease (i.e.: Hepatitis) ……	○ Yes	○ No
Kidney Disease ……	○ Yes	○ No	Kidney Stones ……	○ Yes	○ No
Crohn's/Colitis/Celiac Disease……	○ Yes	○ No			

Have you ever had any of the following procedures?

Gastric Bypass/Lap Band? ……	○ Yes	○ No
Orthopedic hardware/medical devices in your hips and/or spine? ……	○ Yes	○ No
Cancer(s) ……	○ Yes	○ No
If Yes, type(s)? _____ When? _____		
If Yes to Breast Cancer, have you ever taken Aromatase Inhibitor Therapy Drugs:		
[Arimidex (Anastrozole), Femara (Letrozole), Aromasin (Exemestane), etc.]? ……	○ Yes	○ No
Have you ever taken Tamoxifen? ……	○ Yes	○ No
Have you had Radiation Therapy? ……○ Yes ○ No Have you had Chemotherapy? ……	○ Yes	○ No

For practice use only: MRN: _____ DOS: _____

Are you taking/have you taken any of the following medications?

Steroids for 3 months or longer (Prednisone, Cortisone) ..... O Yes O No

If Yes, for what condition(s)? _____

Thyroid medication ..... O Yes O No

Antidepressants (SSRI: Drugs like Prozac)..... O Yes O No

Anti-seizure/epilepsy meds ..... O Yes O No

Insulin Dependent Diabetes ..... O Yes O No

Are you taking or have you ever taken any of the following medications?

Actonel (Risedronate)	O Yes O No	How Long? _____	If Stopped, when? _____
Aredia (Pamidronate).....	O Yes O No	How Long? _____	If Stopped, when? _____
Atelvia (Risedronate)	O Yes O No	How Long? _____	If Stopped, when? _____
Boniva (Ibandronate)	O Yes O No	How Long? _____	If Stopped, when? _____
Duavee (bazedoxifene & conjugated estrogen)...	O Yes O No	How Long? _____	If Stopped, when? _____
Evenity (romosozumab-aqqg)	O Yes O No	How Long? _____	If Stopped, when? _____
Evista (Raloxifene)	O Yes O No	How Long? _____	If Stopped, when? _____
Forteo (Teriparatide)	O Yes O No	How Long? _____	If Stopped, when? _____
Fosamax (Alendronate)	O Yes O No	How Long? _____	If Stopped, when? _____
Miacalcin/Fortical (Calcitonin)	O Yes O No	How Long? _____	If Stopped, when? _____
Prolia (Denosumab)	O Yes O No	How Long? _____	If Stopped, when? _____
Reclast(Zoledronic Acid)	O Yes O No	How Long? _____	If Stopped, when? _____
Tymlos (Abaloparatide)	O Yes O No	How Long? _____	If Stopped, when? _____
Zometa (Zoledronic Acid)	O Yes O No	How Long? _____	If Stopped, when? _____

Do you take any of the following supplements?

Calcium.....	O Yes O No	If Yes, Dose: _____
Vitamin D	O Yes O No	If Yes, Dose: _____
Mulivitamin	O Yes O No	If Yes, Dose: _____

OFFICE USE ONLY

Tallest Height: _____ Height (in):_____ Weight (lbs): _____

Dietary Calcium:

_____

_____

_____

_____

_____

Patient Exercise: O Yes O No

_____

_____

_____

_____

_____

General Comments:

_____

_____

_____

Counseling and educational material given to patient? ..... O Yes O No

Diagnoses: _____

Signature of DEXA Technologist: _____ Date: _____

Physician Signature: _____

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DEXA & Pregnancy

*TO ALL FEMALE PATIENTS BETWEEN 12 AND 55 YEARS OF AGE:

Your physician has requested that you have a Dual Energy X-ray Absorptiometry (DXA) test performed. If you are a female between 12 and 55 years of age we need you to address the following:

The National Council on Radiation Protection and Measurements recommends that X-ray exams of the abdomen, pelvis, hip and/or proximal femur be performed only during the 14 days following the onset of menstruation to prevent exposure to a developing pregnancy.

Is there a chance that you may be pregnant? ☐ Yes ☐ No

If no, does one of the following apply to you?

☐ Hysterectomy *If you checked this, please sign below.

☐ Menopause *If you checked this, please sign below.

If you are using birth control, what method? _____

First day of your last menstrual period? _____

By signing this form, you are advising us of your pregnancy status and giving your consent to undergo the radiologic procedure requested by your physician.

_____ _____
Patient's Name (Please Print) Date of Exam

_____
Patient's Signature

_____
Technologist's Signature

Revised 12/2020

For practice use only: MRN: _____ DOS: _____