LONE STAR
ORTHOPAEDIC AND SPINE SPECIALISTS, PLLC
Gurpreet S. Bajaj, MD Von L. Evans, MD Alfredo L. Marti, MD Jeffrey J. Ratusznik, MD John A.Thomas, MD Christopher P. Werner, DPM

Bone Health & Osteoporosis Clinic ▪ Fracture Liaison Service

Last Name: _____ First Name: _____

DOB: _____ / _____ / _____ □ Male □ Female

Please Circle Your Answers

1. Are you over the age of 50? Yes No

2. Have you ever broken a bone? Yes No
   Age: _____ Location: _____
   Age: _____ Location: _____

3. Has your height decreased over the last several years? Yes No

4. Have you ever had a weight loss procedure or gastric bypass? Yes No

5. Do you or your immediate family have a history of the following? Yes No
   (Check all that apply)

   □ Spinal Fracture □ Hip Fracture □ Osteoporosis

6. Have you taken any of these medications (3mo or more)? Yes No
   (Check all that apply)

   □ Prednisone □ Methylprednisolone □ Dexamethasone
   □ Methotrexate □ Chemotherapy

7. Have you ever (or has it been suggested) taken a medication for your bones? (Check all that apply) Yes No

   □ Fosamax □ Boniva □ Actonel □ Reclast □ Evista
   □ Prolia □ Forteo □ Calcitonin □ Strontium □ Boron

8. Have you had a bone mineral density test (DEXA) in the last 2 yrs? Yes No

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Office use only: □ Reviewed- Appt. not needed Name: _____
□ Schedule

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Practice Consent Form

Consent to Treat

I consent to necessary medical treatment as recommended by my physician. I understand that insurance may not cover all recommended medical services, such as preventative health exams, immunizations, screening test, detailed phone consultations, copies of medical records, or preparation of reports, forms, and summaries.

Patient Initials:_____

Privacy Notification

As permitted by the Health Insurance Portability and Accountability Act (HIPAA), I understand that my protected health information may be used and disclosed by the physician, office staff, and others outside of this office who are involved in my care and treatment for the purpose of providing health care services.

I acknowledge that I have been provided an opportunity to review the Notice of Privacy Practices which explains how my medical information will be used and disclosed. I understand that I am entitled to a copy of this document.

Patient Initials:_____

Release of Information

I authorize Gurpreet S. Bajaj, M.D., Von L. Evans, M.D., John A. Thomas, M.D., Christopher Werner, D.P.M., and Jeffrey J. Ratusznik, M.D. to discuss information with the following:

___ Family Members

___ Coaching/Training Staff at my school. School Name: _____

____ I restrict release of information to only the following:

Name: _____ Relation: _____

Name: _____ Relation: _____

Patient Initials:_____

Medical Record Authorization

I authorize Lone Star Orthopaedic and Spine Specialists to obtain outside medical records including but not limited to Primary Care Physicians, Hospitals, Imaging Centers, and Pharmacies:

Patient Initials:_____

I have read and fully understand the above consent for treatment, financial responsibility, release of medical records information, and insurance authorization. These authorizations shall remain until written notice is given by me revoking said authorization.

Patient Signature: _____ **Date:** _____

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Kirstin Webster, APRN, FNP-BC

Bone Health & Osteoporosis Clinic ▪ Fracture Liaison Service

Date: ___ / ___ / ____

Last Name: _____ **First Name**: _____

DOB: ____ / ____ / ____ **Age:** _____ **Male** □ **Female** □

Please Circle

Yes **No** 1. Are you over the age of 50?

Yes **No** 2. Have you ever fractured or broken a bone (after age 45)?

Age	Bone Involved	Describe Circumstance

Yes **No** 3. Did a parent or sibling have a hip or vertebral (spine) fracture after the age of 50?

Yes **No** 4. Do you currently smoke, vape, or use chewing tobacco?
If No, Are you a Former Smoker? □ No □ Yes, Quit date: _____

Yes **No** 5. Do you drink alcoholic beverages? □ 1-3 drinks per day □ 3+ drinks per day

Yes **No** 6. Have you ever had a weight loss procedure or gastric bypass?

Yes **No** 7. Have you ever taken any of these medications for 3 months or longer?
(Check all that apply)
□ Prednisone □ Methylprednisolone □ Dexamethasone □ Methotrexate
□ Chemotherapy

Yes **No** 8. Do you take any calcium supplements (including TUMS)
If Yes, How much do you take _____

Yes **No** 9. Do you take any Vitamin D supplements?
If Yes, How much do you take _____

Yes **No** 10. Have you ever taken (or has it been suggested you take) a medication for your bones? (Check all that apply)
□ Fosamax □ Boniva □ Actonel □ Reclast □ Evista □ Prolia
□ Forteo □ Tymlos □ Calcitonin □ Strontium □ Boron

Yes **No** 11. Have you had a bone mineral density test (DXA) within the past 2 yrs.?
If Yes, When _____ Where _____

Yes **No** 12. Have you had a barium x-ray in the past two weeks?

Yes **No** 13. Have you had a nuclear medical scan or injection of an x-ray dye in the past week?

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