LONE STAR
ORTHOPAEDIC AND SPINE SPECIALISTS, PLLC
DEDICATED TO RESTORING ACTIVE LIFESTYLES
215 Old Hwy 1187, Burleson TX 76028 —— 929 Lipscomb St, Ft. Worth 76104
817.926.BONE (2663)

First and foremost, we want to express our appreciation to you for selecting our practice. We want all of your experiences with us to be positive.

We know that filling out these forms can be difficult, but please complete them carefully. Your accurate responses will give us a better understanding of you and your problem. This enables us to provide you with the best possible medical care. Thank you for your cooperation!

Please bring your insurance card, driver's license or other picture ID, and all copies of medical records pertaining to your appointment including MRIs, X-rays, and CT scans. We do prefer that you have these on a CD. Please bring copies of the reports with the imaging.

Please confirm prior to your appointment which location you are scheduled at as we have multiple locations.

Again, thank you for selecting Lone Star Orthopaedic and Spine Specialists. Please feel free to call if you have any questions prior to your appointment.

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New Patient Registration

Contact Information

Patient Name (Last, First, MI):_____ Today's Date: _____

Address:_____
Street City State Zip Code

Home Phone:_____ Cell Phone:_____ Work Phone: _____

E-Mail: _____

Primary Care Physician: _____

How did you learn about our practice?

☐ Referred by a Physician:_____ ☐ Internet / Website ☐ Newspaper / Magazine

☐ Referred by a Patient:_____ ☐ Other: _____

Care Plan

Do you have any of the following: ☐ Advance Directive ☐ Designated Power of Attorney ☐ Other: _____

Demographic Information

Date of Birth:_____ Social Security #:_____-_____-_____ Gender: ☐ Male ☐ Female ☐ Other

Marital Status: ☐ Single ☐ Co-Habitating ☐ Married ☐ Divorced ☐ Widow / Widower ☐ Other

Ethnicity:_____ Preferred Language: _____

Employer or School: _____

Is todays visit: **Work Related** ○ Yes ○ No **3rd Party Liability** ○ Yes ○ No **Auto Accident** ○ Yes ○ No

Emergency Contact Information

Contact Name (Last, First, MI):_____ Phone #: _____

Address:_____
Street City State Zip Code

Preferred Pharmacy

Pharmacy Name:_____ Phone #: _____

Primary Insurance Information

Primary Insurance:_____ Phone #: _____

Insured's Name: _____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's Date of Birth:_____ Insured's Social Security #:_____-_____- _____

Employer/Group Name:_____ Group #: _____

ID #: _____

Secondary Insurance Information

Secondary Insurance:_____ ID #: _____

Insured's Name: _____ Insured's Date of Birth: _____

Workers' Compensation Information

Insurance Company:_____ Phone #:_____ Date of Injury: _____

Adjuster's Name: _____ Phone #:_____ Claim #: _____

Patient Signature: _____ Date: _____

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HAND SURGERY INFORMATION

Demographic Information

___ New Patient____Established Patient Visit Date: _____

Name: _____ DOB: _____ Sex: M/F Ht:_____ Weight:_____

Current Symptoms

Hand Dominance: L____ R____

What is your date of injury?_____If this is not an injury, when did the pain start?_____

Is this injury related to: ☐ A Workplace Injury ☐ A Motor Vehicle Accident ☐ A 3rd Party Claim

Please describe how you were injured: _____

Location on the Wrist/Hand: Right / Left / Both_____

Intensity of the pain on a scale of 0-10 (10 being the worst): _____

What helps with the injury/pain? _____

What makes the injury/pain worse? _____

Associated symptoms: ☐ Numbness ☐ Weakness ☐ Popping ☐ Other_____

Previous Treatment

Tell us what you have **already** done or tried for this injury/pain? (meds, physical therapy, etc.):

What studies have you had done for this injury/pain? (X-ray-MRI-CT Scan, etc.):

Current Medications

Please list all medications you are taking, including Prescription, Over-the-counter, and Herbal Medications: ☐ None

Medication	Dose & How Often Taken	Doctor (If Prescription)

(Additional Medications-list on reverse side of form)

Allergies

Please list any allergies to medications, latex, iodine, & tape, including the reaction you experience: ☐ No Known Allergies

Medication	Reaction	Most recent exposure to this Medication

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Past Medical History

For each category, please indicate any conditions which you **currently have** or **have had in the past:**

No Medical Problems

☐ I do not have any current or previous medical conditions

Cardiovascular

☐ Hypertension ☐ Heart Attack ☐ Stroke ☐ TIA (Transient Ischemic Attack)
☐ Atrial Fibrillation ☐ Congestive Heart Failure

Pulmonary

☐ Asthma ☐ COPD ☐ Emphysema ☐ Tuberculosis
☐ Frequent Pneumonia ☐ Sleep Apnea ☐ Supplemental Oxygen Requirement

Gastrointestinal

☐ Gastric Reflux (GERD) ☐ Gastric Ulcer ☐ Hepatitis ☐ Cirrhosis
☐ Liver Disease ☐ Gall Stones ☐ Hernia ☐ IBS / Crohn's Disease / Ulcerative Colitis

Renal

☐ Kidney Stones ☐ Kidney Infection ☐ Renal Insufficiency ☐ Dialysis-Dependent

Genitourinary

☐ Enlarged Prostate (BPH) ☐ Sexual Difficulty ☐ Urinary Incontinence ☐ Menstrual Problems
☐ Frequent or Chronic Urinary Tract Infection (UTI)

Musculoskeletal

☐ Degenerative Arthritis ☐ Rheumatoid Arthritis ☐ Gout ☐ Fibromyalgia
☐ Osteoporosis / Osteopenia ☐ History of Hip Fracture ☐ Vertebral Fracture ☐ Scoliosis

Endocrine

☐ Diabetes ☐ Thyroid Disease ☐ Addison's Disease ☐ Polycystic Ovarian Syndrome (PCOS)

Neurologic / Psychologic

☐ Anxiety ☐ Depression ☐ Bipolar Disorder ☐ Schizophrenia
☐ Peripheral Neuropathy ☐ Carpal Tunnel Syndrome ☐ Alzheimer's Disease ☐ Parkinson's Disease
☐ Multiple Sclerosis ☐ Spinal Cord Injury ☐ Traumatic Brain Injury (TBI)

Hematologic

☐ Anemia ☐ Clotting Disorder ☐ Taking Anti-Coagulant Medications ("Blood Thinners")
☐ Deep Venous Thrombosis (DVT) ☐ Pulmonary Embolism (PE)
☐ History of Blood Transfusion ☐ Sickle-Cell Anemia

Immunologic

☐ Immune Disorder ☐ Long-term Steroid Therapy (e.g. Prednisone) ☐ Immuno-Suppressant Medication
☐ Organ Transplant ☐ Eczema ☐ Psoriasis ☐ Lupus
☐ Sjogen's Syndrome ☐ HIV/AIDS

Cancer

If you have been diagnosed with cancer, or have had cancer in the past, please select the appropriate bubble:

☐ Breast ☐ Lung ☐ Kidney ☐ Thyroid
☐ Prostate ☐ Bowel ☐ Skin ☐ Bone
☐ Leukemia ☐ Lymphoma ☐ Myeloma
☐ Other: _____

Please provide any additional details about type of cancer, when it was diagnosed (approximate year), any treatment (Including any Medications, Radiation, and/or Surgery), the name of your Oncologist, and the approximate date of your most recent Oncology follow-up appointment:

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Past Medical History (Continued)

Additional Medical Problems

If you have any additional medical problems not listed, or need to provide any additional information, please check the bubble marked "yes", and provide details below:

☐ Yes, I have the following medical conditions:

Surgical History

For each category, please indicate any surgeries which you have had:

Head & Neck

☐ Eye Surgery ☐ Sinus Surgery ☐ Facial Reconstructive / Plastic surgery
☐ Oral Surgery ☐ Neck Surgery

Cardiothoracic

☐ Cardiac Bypass ☐ Cardiac Stent ☐ Angioplasty / Cardiac Catheterization
☐ Pacemaker / Defibrillator ☐ Cardiac Valve Surgery ☐ Lung Surgery ☐ Mastectomy

Abdominal

☐ Hernia Repair ☐ Appendectomy ☐ Gastric Bypass ☐ Cholecystectomy (Gallbladder)
☐ Esophageal Surgery ☐ Stomach / Bowel Surgery ☐ Organ Transplant ☐ Kidney Surgery

Pelvic

☐ C-Section ☐ Hysterectomy ☐ Bladder Suspension ☐ Prostate Surgery

Vascular

☐ Varicose Vein Surgery ☐ Aortic Aneurysm Repair ☐ Vascular Bypass ☐ Carotid Endarterectomy
☐ AV Fistula (Dialysis access)

Neurologic

☐ Brain Surgery ☐ Ventricular Shunt ☐ Cervical Spine Surgery ☐ Lumbar Spine Surgery
☐ Scoliosis Surgery ☐ Carpal Tunnel Release ☐ Ulnar Nerve Decompression

Orthopaedic

☐ Fracture Repair ☐ Knee Replacement ☐ Hip Replacement ☐ Shoulder Arthroplasty
☐ Arthroscopic Surgery

Other Surgeries

☐ If you have had any surgeries not present above, please list them here:

Hospitalization

Have you ever been hospitalized, for any reason?

☐ Never ☐ None besides those listed in Surgical History ☐ Yes

If you answered "Yes", please provide details including reason, approximate dates and length of hospital stay:

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Family History

Please indicate any medical conditions affecting your family members:

Mother

☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke
☐ Mental Illness ☐ Cancer ☐ Scoliosis ☐ Skeletal Dysplasia
☐ Genetic Abnormalities ☐ Other ☐ Unknown / Not Applicable

Father

☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke
☐ Mental Illness ☐ Cancer ☐ Scoliosis ☐ Skeletal Dysplasia
☐ Genetic Abnormalities ☐ Other ☐ Unknown / Not Applicable

Siblings

☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke
☐ Mental Illness ☐ Cancer ☐ Scoliosis ☐ Skeletal Dysplasia
☐ Genetic Abnormalities ☐ Other ☐ Unknown / Not Applicable

Children

☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke
☐ Mental Illness ☐ Cancer ☐ Scoliosis ☐ Skeletal Dysplasia
☐ Genetic Abnormalities ☐ Other ☐ Unknown / Not Applicable

If you answered "Other" to any of the above, please provide explanation below:

_____

_____

Social History

Marital Status

☐ Single ☐ Co-Habitating ☐ Married ☐ Separated / Divorced
☐ Widow / Widower

Education

☐ Grammar School ☐ High School ☐ College ☐ Post-Graduate

Employment

What is your current *(or most recent)* Occupation?

_____

Please describe your Current Work Status:

☐ Working - Full Time ☐ Working - Part Time ☐ Seeking Employment ☐ Physically unable to work / Disabled
☐ Not working by choice (Retired - Homemaker - Student - etc.)

Habits

Tobacco & Nicotine Products

☐ Never used ☐ Current / Occasional User ☐ Former user – Quit Date (Approximate):_____

If you are *currently* using Tobacco or Nicotine products, please indicate the Type (select all that apply):

☐ Cigarettes ☐ Cigars ☐ Chewing Tobacco ☐ Nicotine Vaporizer / "e-Cigarette"
☐ Nicotine Gum / Patch

If you are *currently* using Tobacco or Nicotine products, please indicate how often:

☐ Daily ☐ At Least 1x per Week ☐ At Least 1x per Month ☐ Less than Once per Month

Alcohol

☐ Never ☐ Less than 1 drink per Week ☐ Weekly ☐ Daily

Do you have a History of Heavy Drinking or Alcoholism?

☐ Never ☐ In the Past ☐ Current

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Review of Systems

For each category, please indicate all problems which you **currently have**:

Constitutional

☐ None ☐ Fever ☐ Chills ☐ Night Sweats
☐ Recent Unexplained weight Loss (More than 10 Pounds) ☐ Recent Unexplained weight Gain (More than 10 Pounds)

General

☐ None ☐ Muscle Weakness ☐ Difficulty Standing ☐ Difficulty Walking

Head, Eyes, Ears, Nose, & Throat

☐ None ☐ Sinusitis ☐ Congestion ☐ Dentures
☐ Vision Problems ☐ Eye Glasses ☐ Hoarseness ☐ Difficulty Swallowing

Cardiovascular

☐ None ☐ Chest Pain ☐ Shortness of Breath ☐ Ankle / Feet Swelling
☐ Palpitations

Respiratory

☐ None ☐ Cough ☐ Wheezing

Gastrointestinal

☐ None ☐ Constipation ☐ Heartburn ☐ Dark / Bloody Stools
☐ Nausea ☐ Vomiting

Musculoskeletal

☐ None ☐ Neck ☐ Back ☐ Shoulder
☐ Wrist / Hand ☐ Hip ☐ Knee ☐ Ankle / Foot

Integumentary

☐ None ☐ Rash ☐ Itching ☐ Open sores
☐ Poor healing ☐ Acne ☐ Skin infection

Neurology

☐ None ☐ Memory Loss ☐ Confusion ☐ Dizziness
☐ Vertigo ☐ Tremor ☐ Frequent Headache ☐ Balance Problems

Psychiatric

☐ None ☐ Sleep disturbances ☐ Feelings of hopelessness

Genitourinary

☐ None ☐ Urinary incontinence ☐ Pain with Urination ☐ Frequent Urination
☐ Incomplete voiding

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PRACTICE POLICIES

Financial Obligations

I agree that in return for the services provided by Lone Star Orthopaedic and Spine Specialists I will pay my account at the time service is rendered, or will make financial arrangements satisfactory to Lone Star Orthopaedic and Spine Specialists for payment. If my insurance company or health plan designates co-payments and/or deductibles, I agree to pay them to Lone Star Orthopaedic and Spine Specialists. All co-payments and past due balances are due and payable at the time of service. I understand and agree that if my account is delinquent, a collection agency may be authorized to recover the unpaid amount.

Patient Initials:_____

HMO Referrals

If your insurance has designated a primary care physician (PCP), a prior authorization from your PCP is required to see a specialist. It is your responsibility to work with your PCP and insurance carrier to obtain this authorization prior to your office visit with Lone Star Orthopaedic and Spine Specialists. If authorization is not provided, either by you the Patient, or through your Insurance Carrier or PCP, you will be asked to re-schedule your appointment until the authorization is available, or pay for the visit at the time of service and file with your insurance carrier for reimbursement.

Patient Initials:_____

Self-Pay Accounts

Patients without an insurance plan at the time of service, and/or patients who are covered by insurance carrier with whom the practice does not participate, are individually obligated to pay the full charges at the time of service

Patient Initials:_____

Non-Participating Insurance Accounts

Services provided to Patients who are insured by carriers with which the practice does not participate are considered “out-of-network.” It is the financial obligation of the patient with non-participating insurance carriers to pay the co-pay and/or visit in full at the time of service.

Patient Initials:_____

If You Require Surgery

If you require surgery, your surgeon and supporting staff will work with you to select a date that will accommodate both schedules. Our staff will review any anticipated financial responsibilities you may have. Keep in mind that these are estimates only, and are subject to change once the surgery has been billed and insurance has paid. You may be asked to make a pre-payment to cover the amount of your deductible/percentage for surgical care. This payment will be due before surgery is performed.

Please feel free to talk to our staff about a payment plan if you have a special financial situation. Our office will work with you to ensure that you receive the highest quality of care. Lone Star Orthopaedic & Spine Specialists will require that all balances being placed on a payment schedule be paid in full within 6 months – as such, payment plans are structured on a 6-month time frame.

Patient Initials:_____

Returned Checks

All returned checks will be assessed a $35.00 fee.

Patient Initials:_____

Signature:_____ Date: _____

Patient or Authorized Party Signature

Electronic signature: This Agreement may be executed and delivered by electronic means and upon such delivery the electronic signature will be deemed to have the same effect as if the original signature.

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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., Barnard Barragan, M.D., Von L. Evans, M.D., Alfredo L. Marti, M.D., Dalton M. Ryba, D.P.M., 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:** _____

Electronic Signature: This Agreement may be executed and delivered by electronic means and upon such delivery the electronic signature will be deemed to have the same effect as if the original signature.

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Agreement for Opioid Medication Therapy

Introduction

The purpose of this agreement is to give you information about the medications you will be taking for pain management only if that becomes part of your treatment plan and to assure that you and your physician comply with all state and federal regulations concerning the prescribing of controlled substances. A trial of opioid therapy can be considered for moderate to severe pain with the intent of reducing pain and increasing function. The physician's goal is for you to have the best quality of life possible given the reality of your clinical condition. The success of treatment depends on mutual trust and honesty in the physician/patient relationship and full agreement and understanding of the risks and benefits of using opioids to treat pain.

I (patient) understand the following (initial each):

_____ Opioids may be prescribed to me on a trial basis. One of the goals of this treatment is to improve my ability to perform various functions, including return to work. These medications may be prescribed to make my pain tolerable but may not cause it to disappear entirely. If significant demonstrable improvement in my functional capabilities does not result from this trial of treatment, my prescriber may determine to end the trial.

_____ Drowsiness and slowed reflexes can be a side effect of opioids, especially during dosage adjustments. If I am experiencing drowsiness while taking opioids, I agree not to drive a vehicle or perform other tasks that could involve danger to myself or others.

_____ There is a risk that physical dependence or addiction to opioid medications can occur. Longer duration of therapy, higher doses of medications, and personal or family history of other drug or alcohol abuse increase this risk. If it appears that I may be developing addiction, my physician may determine to end the trial.

I agree to the following (initial each):

_____ I agree not to take more medication than prescribed and not to take doses more frequently than prescribed.

_____ I agree to keep the prescribed medication in a safe and secure place, and that lost, damaged, or stolen medication will not be replaced.

_____ I agree not to share, sell, or in any way provide my medication to any other person.

_____ I agree to obtain all prescription medication from one designated licensed pharmacy:

Pharmacy: _____ **Phone:** _____

_____ I understand that my doctor may check a Controlled Substance Database or Prescription Monitoring Program at any time to check my compliance.

_____ I agree not to seek or obtain any mood-modifying medication, including pain relievers, muscle relaxers, or tranquilizers from any other prescriber without first discussing this with my prescriber. If a situation arises in which I have no alternative but to obtain my necessary prescription from another prescriber, I will advise that prescriber of this agreement. I will then immediately advise my prescriber that I obtained a prescription from another prescriber.

_____ I agree to submit to random urine, blood or saliva testing, at my prescriber's request, to verify compliance with my treatment plan, and to undergo be seen by an addiction specialist if requested.

_____ I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine. I authorize my doctor to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations..

I understand that any deviation from the above agreement, at any time, may be grounds immediate cessation of all opioid therapy and may result in termination of the doctor/patient relationship with Dr. Bajaj, Dr. Barragan, Dr. Evans, Dr. Ratusznik, Dr. Ryba, Dr. Thomas, or Dr. Werner.

Patient Signature: _____ **Date:** _____

I obtain my pain medication from my primary care doctor or pain management physician:

Dr. _____, And I will continue to do so until I discuss any changes with Dr. Bajaj, Dr. Barragan, Dr. Evans, Dr. Ratusznik, Dr. Ryba, Dr. Thomas or Dr. Werner.

Patient Signature: _____ **Date:** _____

Electronic Signature: This Agreement may be executed and delivered by electronic means and upon such delivery the electronic signature will be deemed to have the same effect as if the original signature.

- Complaints may be directed to the following State Agency:

OFFICE OF THE OMBUDSMAN
P.O. BOX 13247
AUSTIN, TX 78711-3247
1-877-787-8999

- Web site for the Medicare Beneficiary Ombudsman: www.medicare.gov or 1-800-633-7227 or www.cms.hhs.gov/center/ombudsman

NOTICE TO PATIENTS: Physician Financial Ownership

We are required by Federal law to notify you that physicians hold financial interest or ownership in the following facilities: Baylor Surgicare at Fort Worth, Baylor Surgical Hospital, Gulfstream Surgery Center, Medical City Surgery Center, Texas Health Huguley Surgery Center, USMD Hospital Fort Worth, Precision Reading LLC. We are required by 42 C.F.R. § 416.50 to disclose this financial interest or ownership in writing and in advance of the date of the procedure. A list of physicians who have a financial interest in one of these facilities are listed below:

1. Dr. Gurpreet Bajaj
2. Dr. Barnard Barragan
3. Dr. Von Evans
4. Dr. Alfredo Marti
5. Dr. Jeffrey Ratusznik
6. Dr. Dalton Ryba
7. Dr. John Thomas
8. Dr. Christopher Werner

NOTICE TO PATIENTS: Policy for Advanced Directives

Please note that our Facility's policy on Advanced Directives is that Life sustaining efforts will be initiated and maintained on all patients. If you would like information on developing Advanced Directives, the following website can assist you and includes a description of the State's health and safety laws, and upon request, we will provide you with official State advance directive forms:

http://www.uslivingwillregistry.com/forms.shtm

NOTICE TO PATIENTS: Patient Statement of Responsibilities

1. I will provide accurate information about present and past illnesses, hospitalizations, medications, allergies and "NPO" status.
2. I will make every attempt to understand the implications of my procedure, including risks of refusing treatment, and I will ask for clarification when needed.
3. I will arrive at the scheduled time or notify facility of inability to do so.
4. I will follow all discharge instructions.
5. I will be respectful of the rights of other patients and staff.
6. I will be respectful of others' property.
7. I will immediately inform my physician of change in condition or adverse reaction.
8. I will be responsible for assuring that the financial obligations of my health care are fulfilled as promptly as possible.

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_____ _____

Patient Name Date forms given

This is to confirm that I have received the following forms from my physician to review prior to arriving for my procedure. I also understand that I may contact Lone Star Orthopaedic & Spine Specialists, PLLC in case I have any questions regarding any of these forms.

Patient Statement of Responsibilities

Policy for Advanced Directives

Physician Financial Ownership

Patient Bill of Rights/Complaint Resolution

_____ _____

Signature of Patient or Legal Guardian Date

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Bone Health & Osteoporosis Clinic

Last Name: _____ First Name: _____

DOB: _____ / _____ / _____ ☐ Male ☐ Female

Please Circle Your Answers

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

Yes☐ No☐ 2. Have you ever broken a bone?

Age	Bone Involved	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. Have you ever had a weight loss procedure or gastric bypass?

Yes☐ No☐ 6. Have you taken any of these medications (3mo or more)? (Check all that apply)
□ Prednisone □ Methylprednisolone □ Dexamethasone
□ Methotrexate □ Chemotherapy

Yes☐ No☐ 7. Have you ever(or has it been suggested) taken a medication for your bones?
(Check all that apply)
□ Fosamax □ Boniva □ Actonel □ Reclast □ Evista
□ Prolia □ Forteo □ Calcitonin □ Strontium □ Boron

Yes☐ No☐ 8. Have you had a bone mineral density test(DXA) within the past 2 years?
If yes, when_____ Where_____

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