University Hospitals Bristol and Weston NHS Foundation Trust

Pre DXA Scan Clinical Assessment

Please complete this assessment and bring it with you when you attend for your DXA Scan. If you are unsure of any answer this can be discussed when you attend.
The information provided will help us to interpret your scan results more accurately.

Surname: _____ Forename: _____ Date of Birth: ___/___/____

Hospital Number (From your appointment letter): _____ Sex: Male ❑ Female ❑ Age: _____

1. Have you ever broken or fractured a bone? Yes ❑ No ❑

Bone fractured	**Approximate Age / Year of fracture**	**How did it happen? e.g. fall / Car Accident**

2. Family History

		Mum	Dad	Other
Do you have a family history of Osteoporosis?	Yes ❑ No ❑			
Did / have either of your parents fracture a hip after age 50?	Yes ❑ No ❑			
Did / have either of your parents lost more than 2 inches in height?	Yes ❑ No ❑			

3. Smoking status

	Yes	**No**
Do you smoke?		
Did you previously smoke?		

Never smoked ❑
If yes, current number per day……..
If yes, when / the age you stopped? ……..

4. Weekly Alcohol Consumption **None** ❑

	No. of drinks e.g. 0-1; 3 – 4	**Glass size (**Please circle)	**% Vol**
Wine		Small / Standard / Large / Bottles	
Beer		Bottles / Cans / ½ Pint / Pint	
Spirits		Singles / Doubles/ Bottles	

Official use

None	
<3 units/day	
±3 units/day	
>3 units/day	

5. Oral Steroids (tablets) e.g. Prednisolone **Not Applicable** ❑

Current Steroids – Dose……mg/d	Yes ❑ No ❑	If yes, how long taken for:
Previous long term (3 months or longer)	Yes ❑ No ❑	How long since stopping?
Previous Short term course(s)	Yes ❑ No ❑	No. of courses in last 12 months ……

6. Do you eat or drink dairy products on a daily basis e.g. milk, yoghurt, cheese etc.? Yes ❑ No ❑

7. How would you describe your walking / standing balance? Good ❑ Bad ❑ Moderate ❑ Other ❑

8. How many times have you fallen/stumbled/tripped in the last 12 months? 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4+ ❑

9. Do you use any mobility aids? Stick ❑ Walker ❑ Rollator ❑ Other ❑ None ❑

10. Do you get any lower backache? Yes ❑ No ❑

If yes, how often do you get it? Constant ❑ Frequent ❑ Occasional ❑ Other ❑

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Height ……..……..cm Weight……..……kg BMI…… DAP……..……

Approx height as young adult…… Height loss > 2” Yes □ No □ Kyphosis: Yes □ No □

11. Please tick the corresponding box if you have ever been diagnosed with any of these medical conditions.

Rheumatoid Arthritis		Low testosterone		Anorexia	
Osteoarthritis		Thyroid disease		Multiple sclerosis	
Ankylosing Spondylitis		Hyperparathyroidism		Stroke	
Coeliac disease		Diabetes type 1 (insulin dependent)		Breast cancer	
Ulcerative colitis		Diabetes type 2		Prostate cancer	
Crohn's disease		Hiatus Hernia or Gastric Reflux		Osteogenesis Imperfecta	
Chronic liver disease		Bulimia		Organ Transplant	

12. Have you ever taken any of the following medications? If so please tick and give **approximate** details.
Please bring a medication list with you.

Other medications

Medication	**Yes**	**Start date**	**Finish Date**
Calcium / Vitamin D			
Alendronic Acid (Fosamax; Alendronate)			
Risedronate (Actonel)			
Zoledronate			
Strontium ranelate (Protelos)			
Denosumab (Prolia)			
Teriparatide (Forsteo)			
Etidronate (Didronel)			
Ibandronic Acid (Bonviva)			
Pamidronate			
Raloxifene (Evista)			
HRT			
Tamoxifen			
Aromatase Inhibitors (for breast cancer): e.g. [anastrozole (Arimidex), exemestane (Aromasin), letrozole (Femara)]			
Androgen Deprivation Therapy (for prostate cancer) i.e. (Buserelin; Leuprorelin; Triptorelin)			
Lansoprazole; Omeprazole; Esomeprazole			
Anti-seizure medication			

13. Do you do any regular weight bearing exercise? (includes: regular walking, sports etc)

Yes ❑ No ❑ If YES, what type of exercise do you do and how often?

……

14. Patients of Childbearing Potential:

Age when periods started: _____ Regular? Yes ❑ No ❑ Date of Last Period: _____

Age at menopause: _____ Are you pregnant? Yes ❑ No ❑

Have you ever missed your periods for 6 months or longer at any time, except for when you were pregnant or around the menopause? Yes ❑ No ❑

Have you had a hysterectomy? Yes ❑ No ❑ If yes, at what age: _____

Have you had one or more ovaries removed? Yes ❑ No ❑ If yes, at what age: _____

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Pregnancy status below, if aged 12 - 55 years:

As far as I am aware I am not pregnant……Date…… Operator ……..

Assessment complete - Proceed Yes □ **or** No □: Document reason why not: **Sign…… Date……**