Ocean Medical Imaging

Milton Medical Park
611 Federal Street Suite 4
Milton DE 19968

Osteoporosis Assessment Form

Date: ___/____/_____

Patient Name_____(please print). Date of Birth:_____

Answer the questions by checking the appropriate response to the right.
(yes, no , don't know) if answer is yes enter additional information in box at left.

	Yes	No
Gynecologic History (women only)		
Are (were) your periods regular between ages 18 and 40 years?		
Did you ever have intervals with few or no bleeding cycles, other than during pregnancy?	YES	NO
Age: Length of time		
Medications		
Are you now taking hormone replacement pills or using patches?	YES	NO
Do you take cortisone, prednisone, or other steroids for treatment for asthma, arthritis or cancer.	YES	NO
Do you ever take sleeping pills? If yes, how often.	YES	NO
Lifestyle		
Do you take thyroid medication?	YES	NO
Do you smoke? Amount/day:	YES	NO
Fractures and Falls		
Have you ever broken any bones? Year : Site : How:	YES	NO
History of Osteoporosis and Back Pain		
Does anyone in your immediate family have osteoporosis? Mother Father Sister(s) Brother (s)	YES	NO
Do you ever have back pain? Mild Severe Dull Sharp Intermittent constant	YES	NO