

DOCTORS RADIOLOGY CENTER

Date _____

Patient Name (print) _____

Date of Birth _____

Answer the questions by checking the appropriate response (yes, no, don't know) to the right. If your answer is "yes", enter additional information in box at left.	Yes	No	Don't know
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? Age Length of time			
• Have you had a hysterectomy? If yes which Year:			
• If "yes" were your ovaries also removed?			
• Have you entered menopause? If yes which Year:			
Medications			
• Are you now taking hormone replacement pills or using patches?			
• Do you take cortisone, prednisone, or other steroids for treatment of asthma, arthritis, or cancer?			
• Are you now taking calcium supplements? If so, does it contain Vitamin D?			
Lifestyle			
• Do you take thyroid medication?			
• Do you smoke cigarettes? Packs/day			
• Do you drink alcoholic beverages? Drinks/day			
• Do you exercise regularly? Amount/day?			
Fractures and falls			
• Have you ever broken any bones? Year Site How			
History of osteoporosis and back pain			
• Does anyone in your immediate family have osteoporosis? Mother Father Sister(s) Brother(s)			
• Do you ever have back pain? Circle choices: Mild or severe, dull or sharp, intermittent or constant			