CENTER FOR BALANCED HEALTH

NAME: _____

DATE OF BIRTH: _____

PHONE: _____

DATE: _____

Osteoporosis Screening

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 the box at left.

Gyn History (women only)	Yes	No	Don't Know
• Are (were) your periods regular between ages 18 and 40 years old?			
• Did you ever miss cycles other than during pregnancy? Age_____ Length of Time:_____			
• Have you had a hysterectomy? If yes, What year?_____ If yes, Were your ovaries also removed?_____			
• Have you entered menopause? If yes, What year?_____			
Medications			
• Are you taking calcium? With Vitamin D_____ Without Vitamin D_____			
• Are you taking Fosamax?			
• Are you taking Actonel?			
• Are you now taking hormone replacement pills or using patches?			
• Do you take cortisone, prednisone, or other steroids for treatments of asthma, arthritis, or cancer?			
Lifestyle			
• Do you take thyroid medications?			
• Do you smoke cigarettes? Packs per day_____			
• Do you drink alcoholic beverages? Drinks per day_____			
• Do you drink caffeinated beverages? Drinks per day_____			
• Do you exercise regularly? Amount per day_____			
Fractures and falls			
• Have you ever broken any bones? Year_____ Site_____ How_____ Year_____ Site_____ How_____ Year_____ Site_____ How_____ 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(s)? Circle Choices: Mild/Severe Dull/Sharp Intermittent/Constant			

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