

Osteoporosis Assessment Form

Don't forget to bring this form to your next doctor visit.

Date _____

Patient Name (please 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?			
Do you ever take sleeping pills? If yes, how often: _____			
Lifestyle			
Do you take thyroid medication?			
Do you smoke cigarettes? Packs/day: _____			
Do you drink alcoholic beverages? Drinks/day: _____			
Do you drink beverages with caffeine? (coffee, tea, cola)			
Do you exercise regularly? Amount/day: _____			
Fractures and falls			
Have you ever broken any bones? Year(s): _____ Site(s): _____ How: _____			
History of osteoporosis and back pain			
Does anyone in your immediate family have osteoporosis? <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister(s) <input type="checkbox"/> Brother(s)			
Do you ever have back pain? <input type="checkbox"/> Mild or <input type="checkbox"/> Severe <input type="checkbox"/> Dull or <input type="checkbox"/> Sharp <input type="checkbox"/> Intermittent or <input type="checkbox"/> Constant			

Source: Guidelines of care on Osteoporosis for the primary care physician, presented by the Foundation for Osteoporosis Research and Education, Sec. III, July 1997



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