



# Rock Creek Imaging

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Answer the questions by checking the appropriate response (yes, no, don't know) to	Yes	No	Don't
<b>Gynecologic History (women only)</b>			
• 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? If yes, 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: _____			
<b>Medications</b>			
• 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 _____			
<b>Lifestyle</b>			
• Do you take thyroid medication?			
• Do you smoke cigarettes? If yes, _____ packs/day			
• Do you drink alcoholic beverages? If yes, _____ drinks/day			
• Do you drink caffeinated beverages? If yes, _____ drinks/day			
• Do you exercise regularly? If yes, _____ minutes/day			
<b>Fractures &amp; Falls</b>			
• Have you ever broken any bones? If yes, _____ year Site: _____ How? _____			
• Have you experience height loss?			
• Do you experience frequent falls?			
<b>History of Osteoporosis &amp; Back Pain</b>			
• 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? If yes, <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			
• What is your height? _____ weight? _____			