RapidSound, Inc / Green Valley Imaging
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Green Valley, AZ 85622
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OSTEOPOROSIS EVALUATION FORM

Name: _____ Date of Birth: _____/_____/_____ MRN: _____

Doctor: _____ Date of Service: _____

Ethnicity (circle one): Caucasian African American Hispanic Asian

Menopause Age: _____

Is there any chance of you being pregnant? Yes _____ No _____

Do you have a family history of osteoporosis? Yes _____ No _____

Do you smoke? Yes _____ No _____

Have you ever smoked? Yes _____ No _____

Do you drink more than 3 alcoholic beverages daily? Yes _____ No _____

Have you fractured any bones as an ADULT? Yes _____ No _____

List Bones: _____

Have either your parents fractured their hip? Yes _____ No _____

Are there any metal plates, pins, rods or screws in your body? Yes _____ No _____

If Yes, where? _____

Any known history of rheumatoid arthritis? Yes _____ No _____

Any known history of spine curvature? Yes _____ No _____

Are you taking hormone replacement therapy drugs? Yes _____ No _____

If Yes, what and for how long? _____

Are you taking prescription medications for your bones? Yes _____ No _____
(i.e. Fosamax, Actonel, Miacalcin)

If Yes, what and for how long? _____

Are you taking any steroid or thyroid medications? Yes _____ No _____

If Yes, what and for how long? _____

Are you taking any BONE supplements? Yes _____ No _____

If Yes, what and for how long? _____

For Technologist Only

Height: _____ Weight: _____

Diag: _____ Tech: _____

Priors: _____