PEDIATRIC SCOLIOSIS/KYPHOSIS PATIENT QUESTIONNAIRE

This is a questionnaire for your completion. Please fill out the form completely and neatly. If you have any questions, please ask the nurse. Thank you for your cooperation.

DATE: _________________________

PATIENT NAME: _________________________________ Birthdate: ___________________

Age (years + months): _______________________

1. Past medical problems: ___________________________________________________
   _______________________________________________________________________
   _______________________________________________________________________

2. List any significant illnesses that run in your family: _________________________
   _______________________________________________________________________
   _______________________________________________________________________

3. Smoker? No Yes, ___ packs per day for ____year(s). Daily alcohol: ______________

4. List past surgical procedures and dates: _____________________________________
   _______________________________________________________________________
   _______________________________________________________________________

5. Current medications taken on a regular basis: ________________________________
   _______________________________________________________________________

6. Approximate height: ________________ and weight: ________________

7. Approximate growth in the last visit and months: ____________________________
8. Height of mother: ________________________________________________________

9. Height of father: ________________________________________________________

10. Height of siblings: ____________________________________________________

11. How was scoliosis/kyphosis discovered? __________________________________

12. Previous treatment for scoliosis/kyphosis: _________________________________

13. Have menses/periods begun? No Yes Approximate date when begun: __________

   Are they regular? No Yes

14. Do you know your present curve measurement? _____________________________

15. Latest x-ray, date and location: __________________________________________

16. Do you have any spinal pain? If so, describe: ______________________________

17. Do you have weakness/numbness in legs? If so, where is weakness? __________

   Where is numbness? ______________________________________________________

18. Do you have difficulty with control of bowel/bladder? If so, describe: ________

19. Referring physician or primary care physician, address and phone #: ____________

20. Pediatrician, address and phone #: ________________________________________

21. Previous physicians seen for treatment of scoliosis/kyphosis: _________________