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Pediatric Scoliosis/Kyphosis Patient Questionaire

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 past surgical procedures and dates:_____

   _____

3. List any significant illnesses that run in your family:_____

   _____

4. Current medications taken on a regular basis:_____

   Allergies to medications: _____

5. Approximate height: _____ Weight:_____
6. Approximate growth in last 6 months: _____
7. Height of mother _____ Height of father:_____
8. Height of siblings:_____
9. How was scoliosis/kyphosis discovered? _____
10. Previous treatment for scoliosis/ kyphosis: _____

11. Have menses/period begun? Y or N Approximate Date Begun: _____ Are they regular? Y or N
12. Do you know your current curve measurement, if so what is it:_____

    _____
13. Latest x-ray, date and location:_____
14. Do you have any spinal pain? If so, describe:_____

    _____
15. Do you have weakness/numbness in legs? If so, where is weakness? Where is numbness?

    _____

    _____
16. Do you have difficulty with bladder/bowel control? If so, describe:_____

    _____
17. Referring physician or primary care physician, address and phone number:_____

    _____
18. Pediatrician, address and phone number:_____

    _____
19. Previous physicians seen for treatment of scoliosis/kyphosis:_____

    _____
20. My insurance is (circle appropriate answer):

    Workman's Comp Medicare Medicare plus supplement

    Medicaid Private Ins PPO HMO