

## PEDIATRIC SCOLIOSIS/KYPHOSIS PATIENT QUESTIONNAIRE

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

DATE:	
PATIE	ENT NAME: Birthdate:
Age (y	rears + months):
1.	Past medical problems:
2.	List any significant illnesses that run in your family:
3.	Smoker? No Yes, packs per day foryear(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:	