Orthopaedic Surgical Associates
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Adult and Pediatric Spine Survey

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SCOLIOSIS PATIENT QUESTIONNAIRE

Please answer all questions completely. It is in your best interest and will assist your doctor with your care. Thank you for your cooperation.

Date: ____________________
Patient's Name: ____________________
Birthdate: _____/_____/_____
Age: (years & months) ____________________

1. Past Medical Problems:
____
____
____

2. List any significant illness that runs in your family:
____
____
____

3. Is there any history of scoliosis in your family? Yes No

4. List surgical procedures and dates:
____
____
____

5. Current medications taken on a regular basis:
____
____
____

6. Approximate height: ________ and weight: ________

7. Approximate growth in last six months: ________

8. Height of Mother: ________ Height of Father: ________

9. Height of Siblings: ________, ________, ________, ________, ________

10. How was scoliosis / kyphosis discovered?

____

____

____

11. Previous treatment for scoliosis / kyphosis?

____

____

____

12. For girls, have periods begun? _____No _____Yes
If yes, date of first period? ____/____/____
Are they regular? _____No _____Yes

13. Do you have any spinal pain? If so, describe.

____

____

____

14. Do you have weakness/ numbness in legs? _____No _____Yes
If so, where is weakness?

____

Where is numbness?

____

15. Do you have difficulty with control of bowel / bladder? ____No ____Yes
If so, describe.

____

16. Previous physician(s) seen for treatment of scoliosis / kyphosis?

____