

SCOLIOSIS INFORMATION

Date Filled Out _____

Last Name _____ First Name _____ MI _____ Age _____ Birth date _____
Occupation: _____ Gender M F

Who First Noticed the Scoliosis?

Me
Parents or Siblings
School Screening
My Doctor Name of Doctor _____

Primary Care Doctor's Name

Other Doctors Names

How Long Ago Was it First Noticed? _____

Have You Had Any Tests Done For This?

X-rays
MRI
Bone Scan
CAT Scan
Myelogram

What Treatments Have You Had For This?

Nothing Electrical Stimulation
Physical Therapy Brace
Back Exercises
Chiropractic
Massage
Other: _____

Current Symptoms

Do you have any of these **Symptoms now?**

Back Pain
Shoulder Pain Rt. Lt.
Leg Pain Rt. Lt.
Numbness Where: _____
Tingling Where: _____
Arm or Leg Muscle Weakness
Explain: _____
Trouble Controlling Bowels or Bladder
Pain with Coughing, Sneezing or Straining
Pain that wakes you from Sleep

Does Anyone Else in Your Family

Have Scoliosis? Yes No
If Yes Who? _____

If you have a family member with any of the following diseases please check.

Marphan's
Neurofibromatosis
Muscular Dystrophy
Charcot-Marie-Tooth

Do you get any **Regular Exercise?** Yes No If Yes What? _____
How Many days per Week? _____

Do You Have Any of the Following **Symptoms?** (Check all that apply.)

Feeling Sick Weight Loss Fevers Shaking Chills Nausea
Morning Stiffness
Electrical Shock Feelings Visual Disturbance Balance Problems
Trouble Writing Difficulty with fine manipulations
Buzzing Sensation in Arms or Legs

Previous Scoliosis Treatment

Have You Had **Surgery on Your Back** Before? Yes No
If Yes Please List the Type of **Operation**, Approximate Year, and Doctor's Name

	Operation	Year	Doctor
1)	_____	_____	_____
2)	_____	_____	_____
3)	_____	_____	_____
4)	_____	_____	_____

Past Surgical History

(Don't include operations listed above)

Social History

How Far Did You Get In **School**?

Didn't Graduate High School HS Grad
Some College College Grad
Professional or Advanced Degree

Are You **Married**? Yes No

How Many **Children**? 1 2 3 4 5 6

Are You **Working**? Disabled Retired Working
Parenting Taking Time off Unemployed

Operation

Year

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____
- 6) _____
- 7) _____

Previous Medical Problems

Please Check Any Medical Problems You Have Had or Currently Have

Cardiac

Hypertension
Coronary Artery Disease
Myocardial Infarction
Congestive Heart Disease
Atrial Fibrillation
High Cholesterol

Respiratory

COPD
Asthma

Endocrine

Diabetes
Hypo- Thyroidism
Hyper – Thyroidism

GI

Irritable Bowel Syndrome
Colon Cancer
Diverticulitis
GE Reflux
Hepatitis
Ulcer Disease

Urinary and Genital

Enlarged Prostate
Kidney Stone
Urinary Tract Infection
Prostate Cancer
Bladder Cancer
Renal Cancer
Ovarian Cancer
Uterine Cancer

Musculoskeletal

Degenerative Arthritis
Of: _____
Rheumatoid Arthritis
Fibromyalgia
Neck Pain
Upper Back Pain

Skin

Melanoma
Other Skin Cancer
Psoriasis

Neurologic

Multiple Sclerosis
Parkinson's
Stroke
Peripheral Neuropathy

Psychiatric/ Emotional

Alcoholism
Drug Use / Abuse
Depression
Anxiety Disorder
Bipolar Disorder

Blood Disorders

HIV
Bleeding Disorder
Anemia
Leukemia
Lymphoma

Ear/Nose/ Throat

Lip/ Tongue or Throat Cancer
Chronic Sinusitis
Hearing Problems

Enter **Any Other Medical Problems Not Listed** Above Here: _____

Please List Any **Allergies to Medicines**? _____

Please List **All Regular Medications**? _____

Do You **Smoke**? Yes No If Yes, how many packs per Day: _____

Alcohol: How Many **Drinks**, Glasses of Wine or Beers **per Day**: **Never** <1 1 2 3 4 5

Are there Any **Medical Problems That Run in the Family**?
