PROLIANCE ORTHOPAEDICS & SPORTS MEDICINE
BELLEVUE • ISSAQUAH • REDMOND

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) ____

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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

Past Surgical History

(Don't include operations listed above)

	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**?

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