

# ORTHOPAEDIC SURGERY ASSOCIATES OF MARQUETTE, P.C.

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## PEDIATRIC SPINE PATIENT QUESTIONNAIRE

Answer accurately to help us evaluate and treat your child's problem. Ask the nurse if you have questions.

DATE \_\_\_\_\_ NAME \_\_\_\_\_ AGE \_\_\_\_\_ SEX: M  F

Who referred you to this clinic? (name and address)

Name of your primary care physician (name and address):

### ONSET

When was the problem noted (month and year)? \_\_\_\_\_

How was the problem noted? School screening  Parents/Family/Friends  Pediatrician/doctor

What was noted? Shoulder asymmetry  Rib or back prominence  Round back  Sway back  Other \_\_\_\_\_

Has the deformity been getting worse? Yes  No  Do you wear clothing to hide your shape? Yes  No

### QUALITY AND LOCATION OF ANY PAIN

Nature: Sharp  Dull Ache  Burning  Numbness  Pins & Needles

Area: Upper back pain  Low back pain  Neck pain  Leg pain: right  left  Arm pain: right  left

Severity of pain: (On a scale of 1 to 10, 10 being worst possible)

Rated at its worse, what # \_\_\_\_\_ At its best what # \_\_\_\_\_

### What affects the pain?

Worse with: Standing  Walking  Sitting  Lying  Coughing  Bathroom  No difference

Better with: Standing  Walking  Sitting  Lying  No difference

### Time-Dependent Pattern

Progress: Improving  Same  Getting Worse  Worse in: Morning  Afternoon  Night

Other characteristics about your pain: \_\_\_\_\_

### MOTOR FUNCTION

Weakness in: Arms  Legs  Both  Where? \_\_\_\_\_

Trouble with balance, equilibrium or walking? Yes  No  Problems with: Bowel or Bladder: Yes  No

### PAST MEDICAL HISTORY:

Past medical problems: \_\_\_\_\_

Past surgeries: \_\_\_\_\_

### Developmental history:

At how many months of age did the patient: Sit by self? \_\_\_\_\_ Stand alone? \_\_\_\_\_ Walk alone? \_\_\_\_\_

Ride a bicycle? \_\_\_\_\_ If a female patient: age and date of first menstrual period (month and year): \_\_\_\_\_

Can the child keep up physically with their friends of similar age? Yes  No  If no, Describe: \_\_\_\_\_

ALLERGIES: Yes  No  If yes, Describe: \_\_\_\_\_

### MEDICATIONS:

List all current medications: \_\_\_\_\_

### FAMILY HISTORY:

Siblings: # of brothers: \_\_\_\_\_ # of sisters: \_\_\_\_\_ Parents: both at home:  single parent: mom  dad  Other: \_\_\_\_\_

Are there spine problems in the family? Yes  No  Other medical problems in family members? Yes  No

Please list who and what is wrong: \_\_\_\_\_

### SOCIAL HISTORY

Grade level: \_\_\_\_\_ Job/work: \_\_\_\_\_

Smoking: Yes  No  Oral tobacco (chew/snuff) Yes  No  Alcohol / Drug use: Yes  No

### CONSTITUTIONAL SIGNS / REVIEW OF SYSTEMS: (check areas giving trouble and explain to the doctor)

fever	<input type="checkbox"/>	eye problems	<input type="checkbox"/>	cough	<input type="checkbox"/>
night sweats	<input type="checkbox"/>	ear problems	<input type="checkbox"/>	breathing difficulty	<input type="checkbox"/>
cold sweats	<input type="checkbox"/>	nose problems	<input type="checkbox"/>	bleeding problems	<input type="checkbox"/>
weight loss	<input type="checkbox"/>	throat problems	<input type="checkbox"/>	stomach pain	<input type="checkbox"/>
weight gain	<input type="checkbox"/>	chest pain	<input type="checkbox"/>	urinary dysfunction	<input type="checkbox"/>
vision problems	<input type="checkbox"/>	palpitations	<input type="checkbox"/>	bowel dysfunction	<input type="checkbox"/>

“Is there anything else bothering you?” \_\_\_\_\_