The Mount Sinai Medical Center

Filled out by: ________________________
Relationship to patient: ________________

Department of Orthopedics Pediatric Spine Patient Questionnaire

Name: ____Date: ______________________________

Date of Birth: ____________ Height: _____ Ft. _____ In. Weight: _____ lbs. ___ Male ___Female

Growth in past 6 months:____________________________

Height of Mother:____________ Father:____________Siblings:___________________

Referring physician's name and address: ____
____

Internist/family medicine doctor/pediatrician's name and address:_______________________________
____

Why is the child seeing the doctor today? ____

How was the problem discovered? ____

How long has the problem been present? ____

Has the problem worsened recently? ___ No ___Yes, how recently? _______________________

If spinal pain is present, what makes it better? ____

Does the patient have weakness/numbness in his/her legs? ___ Yes ___ No

Are there any problems with loss of bowel or bladder control? ___ Yes ___ No

Previous physicians consulted for this problem:

Physician	Specialty	City	Treatments

Menstrual History: Age at first menstrual period? ____
Date of last menstrual period ____
Are the periods regular? ___ Yes ___ No
Is there any chance the patient could be pregnant? ___ Yes ___ No

Medications Patient Takes: ___ No Medications

Medication	Dose	How long have you been taking?

Is the child allergic to any medication? ___ No allergies ___ Yes, please list: __________________________
____

Please explain any birth complications: ____

Samuel K. Cho, M.D.

Medical History / Review of Systems:
Has the patient been diagnosed with having difficulties in any of the following areas?

___ADD/Attention Deficit/Hyperactivity

___AIDS/HIV

___Arthritis

___Asthma

___Blurred Vision

___Cancer

___Cerebral Palsy

___Diabetes

___Difficulty swallowing

___Down Syndrome

___Earache

___Fever

___Heart Disease

___Hemophilia (bleeding disorder)

___Kidney/Bladder problems

___Lead Poisoning

___Loss of appetite

___Marfan Syndrome

___Muscular Dystrophy

___Neurofibromatosis

___Nosebleeds

___Rickets

___Seizures

___Spina Bifida

___Tuberculosis (TB)

___Weight Gain/Loss

Is the child's pediatrician aware of any of these problems to which you answered yes? ___ No ___Yes

Is the child having any problems that were not listed above? ___ No ___Yes, please explain: ________

Has the patient ever had general anesthesia? ___No ___Yes, if so any problems related to this? ___No ___Yes

Please explain problems related to general anesthesia: ____

Hospitalizations? ___No ___Yes, please list cause and year of hospitalization(s):________________________

Surgical History:

Hospital/Surgeon	Date	Type of Surgery

Social History:
Patient's parents are: ___ Married ___ Divorced ___ Separated ___ Not Married
Patient lives with: ___ Both Parents ___ Mother ___ Father ___ Foster Parents ___ Other ________________
Number of brothers/sisters: ________________________

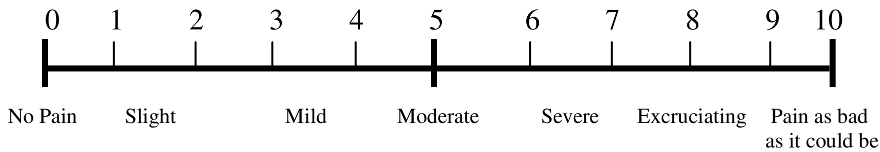
Family History: Do the patient's parents, brothers, or sisters have any of the following? **Check all that apply**.

___Cancer ___Diabetes ___Heart Disease ___High blood pressure ___Kidney disease
___Psychiatric illness ___Stroke ___Bowlegs ___Hip Dysplasia ___Leg Perthes
___Knock Knee ___Roundback ___Low back pain ___Scoliosis (Curved spine)

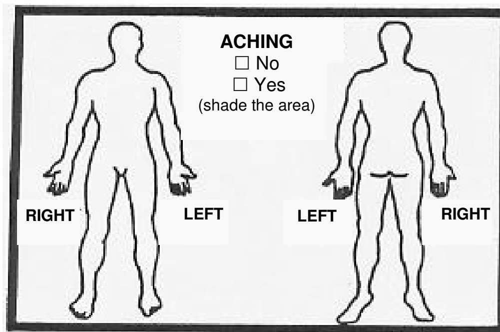
Does the patient smoke? ___ Yes ___ No If yes, _____packs/day x ___years.

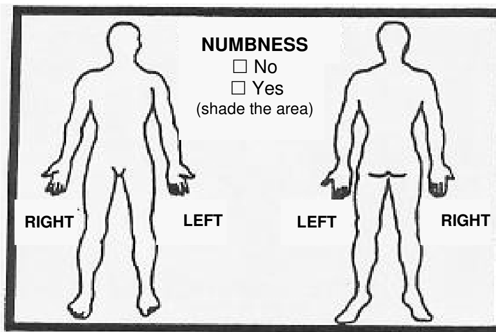
Is there smoking in the house? ___Yes ___No

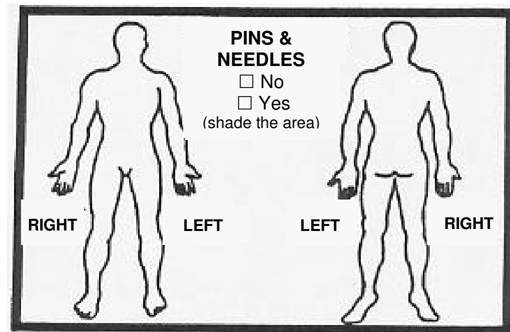
MY PAIN / DISCOMFORT IS (circle number)

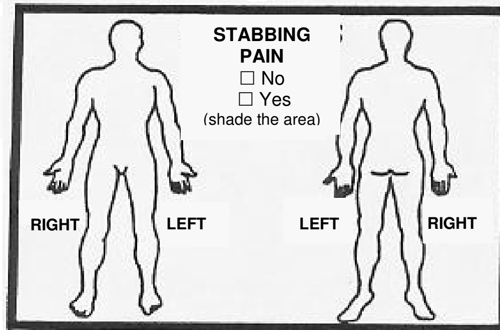


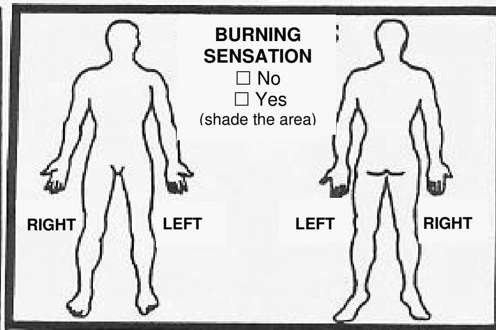
******If back or leg pain or other symptoms are present, please complete the following diagrams:******











Please circle the ONE statement that best describes your average ability:

01. Pain Intensity
- ◯ I can tolerate the pain I have without having to use pain killers.
- ◯ The pain is bad but I manage without taking pain killers.
- ◯ Pain killers give complete relief from pain.
- ◯ Pain killers give moderate relief from pain.
- ◯ Pain killers give very little relief from pain.
- ◯ Pain killers have no effect on the pain, I do not use them.

02. Personal Care (Washing, Dressing, etc.)
- ◯ I can look after myself normally without it causing extra pain.
- ◯ I can look after myself normally but it causes extra pain.
- ◯ It is painful to look after myself and I am slow and careful.
- ◯ I need some help but manage most of my personal care.
- ◯ I need help everyday in most aspects of self care.
- ◯ I do not get dressed, wash with difficulty and stay in bed.

03. Lifting
- ◯ I can lift heavy weights without extra pain.
- ◯ I can lift heavy weights but it gives extra pain.
- ◯ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned. (e.g., on a table.)
- ◯ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ◯ I can lift only very light weights.
- ◯ I cannot lift or carry anything at all.

04. Walking
- ◯ Pain does not prevent me from walking any distance.
- ◯ Pain prevents me walking more than 1 mile.
- ◯ Pain prevents me walking more than 1/2 mile.
- ◯ Pain prevents me walking more than 1/4 mile.
- ◯ I can only walk using a stick or crutches.
- ◯ I am in bed most of the time and have to crawl to the toilet.

05. Sitting
- ◯ I can sit in any chair as long as I like.
- ◯ I can only sit in my favorite chair as long as I like.
- ◯ Pain prevents me from sitting more than one hour.
- ◯ Pain prevents me from sitting more than thirty minutes.
- ◯ Pain prevents me from sitting more than ten minutes.
- ◯ Pain prevents me from sitting at all.

06. Standing
- ◯ I can stand as long as I want without extra pain.
- ◯ I can stand as long as I want but it gives extra pain.
- ◯ Pain prevents me from standing more than one hour.
- ◯ Pain prevents me from standing more than thirty minutes.
- ◯ Pain prevents me from standing more than ten minutes.
- ◯ Pain prevents me from standing at all.

07. Sleeping
- ◯ Pain does not prevent me from sleeping well.
- ◯ I can sleep well only by using tablets.
- ◯ Even when I take tablets I have less than six hours sleep.
- ◯ Even when I take tablets I have less than four hours sleep.
- ◯ Even when I take tablets I have less than two hours sleep.
- ◯ Pain prevents me from sleeping at all.

08. Employment/Homemaking
- ◯ My normal homemaking/job activities do not cause pain.
- ◯ My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
- ◯ I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities. (e.g. lifting, vacuuming).
- ◯ Pain prevents me from doing anything but light duties.
- ◯ Pain prevents me from doing even light duties.
- ◯ Pain prevents me from performing any job or homemaking chores.

09. Social Life
- ◯ My social life is normal and gives me no extra pain.
- ◯ My social life is normal but increases the degree of pain.
- ◯ Pain has no significant effect on my social life apart from limiting my more energetic interests, (e.g., dancing, etc.).
- ◯ Pain has restricted my social life and I do not go out as often.
- ◯ Pain has restricted my social life to home.
- ◯ I have no social life because of pain.

10. Traveling
- ◯ I can travel anywhere without extra pain.
- ◯ I can travel anywhere but it gives extra pain.
- ◯ Pain is bad but I manage journeys over two hours.
- ◯ Pain restricts me to journeys less than one hour.
- ◯ Pain restricts me to short journeys under thirty minutes.
- ◯ Pain prevents me from traveling except to the doctor or hospital.

Is there any other information the doctor should be aware of? ____

____

Attending Physician Signature: I have reviewed the above comprehensive patient history:

Reviewed by: ____ Date: _________________________________