Dynamic Medical Imaging

Stand-up MRI
CT
Ultrasound
X-Ray

LUMBAR/THORACIC SPINE CT/MR QUESTIONNAIRE

DATE_______________

Name___________________________DOB_______________________AGE________

What complaints or symptoms lead you to see your doctor?________________________

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How long have you had these symptoms?______________________________________

Have you ever had trauma or injury to your lower back?______When?________________

If you suspect trauma or injury to have caused your pain, please describe how it occurred:____

____.

Do you have back pain?_______For how long?__________________________________

Do you have pain, numbness or tingling in any of the following areas? Please check where appropriate:

	LEFT	RIGHT
Buttocks	____	_____
Front of thigh	____	_____
Back of thigh	____	_____
Calf	____	_____
Foot near big toe	____	_____
Foot near small toe	____	_____

Do you have difficulty urinating?___________

Do you have weakness of the legs?_______ Left______ Right_______

Do you have difficulty raising your foot?______ Left______ Right_______

Do you have difficulty lowering your foot?_____ Left______ Right_______

Please list any other medical problems that you have, or have had in the past.

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Please list any and all medications you are currently taking.

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Patient's Signature____