



Advanced Imaging Newport Coast

PATIENT QUESTIONNAIRE

MRI LUMBAR SPINE

Please complete the following questions as best as you can

NAME : _____ DATE : _____

Do you have :

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Back Pain | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Leg Pain (Left_____ Right_____) | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Pain Worse on (Left_____ Right_____) | | |
| 4. Numbness | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Tingling on toes | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. History of Cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you had surgery on this area ? | <input type="checkbox"/> | <input type="checkbox"/> |

What was done ? _____ When ? _____

How long have you had this problem ? _____

Describe your pain/symptoms :

- Sharp** **Burning**
- Dull** **Aching**

How did the problem occur ?

- Accident** **Lifting** **Surgery** **Illness**