Advanced Imaging Newport Coast

PATIENT QUESTIONNAIRE

MRI THORACIC SPINE

Please complete the following questions as best as you can

NAME : ____ **DATE :** __________________

Do you have :

	Yes	No
1. Back Pain		
2. Pain Arm (Left______ Right_____)		
3. Pain Leg (Left______ Right_____)		
4. Pain Worse on .... (Left______ Right_____)		
5. Numbness/Tingling		
6. History of Cancer		
7. Have you had surgery on this area ?		

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**