ABERCROMBIE RADIOLOGICAL CONSULTANTS, INC.

MRI LUMBAR SPINE

NAME: _____ DATE: _____

DOB: _____

For MRI Lumbar spine exams please complete the following:

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

Right	Left		Right	Left	
❑	❑	Buttocks	❑	❑	Calf
❑	❑	Front of thigh	❑	❑	Foot near big toe
❑	❑	Back of thigh	❑	❑	Foot near small toe

YES	NO	
❑	❑	Do you have low back pain? (If yes, for how long?) _____
❑	❑	Do you have any weakness of the right leg?
❑	❑	Do you have any weakness of the left leg?
❑	❑	Do you have difficulty in raising your foot? (Please circle if yes) Left Right
❑	❑	Do you have difficulty in lowering your foot? (Please circle if yes) Left Right
❑	❑	Do you unnaturally retain urine?
❑	❑	Have you had back surgery? (If yes, when?) _____
		Do you know what level you had back surgery? (Please circle) L3-L4 L4-L5 L5-S1