ABERCROMBIE RADIOLOGICAL CONSULTANTS, INC.

SPECIAL PROCEDURES/LUMBAR SPINE

NAME: _____ DATE: _____

DOB: _____

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