ABERCROMBIE RADIOLOGICAL CONSULTANTS, INC.
SPECIAL PROCEDURES / LUMBAR SPINE

NAME: _____ Date: _____

Procedure requested: (Please circle) DOB: _____

Breast Biopsy	Arthrogram	Joint Block
Breast Cyst Aspiration	Baker Cyst Aspiration	Myelogram
MRI Breast Biopsy	Steroid Injection	Epidural

Are you taking any of the following medications?

YES	NO		Name of Medication	Last Date Taken
❑	❑	Aspirin	_____	_____
❑	❑	Anti-inflammatory	_____	_____
❑	❑	Blood thinners	_____	_____
❑	❑	Arthritis medication	_____	_____
❑	❑	Pain medication	_____	_____

Are you allergic to Lidocaine, Betadine or Latex? (Please circle if YES)

Are you allergic to any other medications? If yes, please list: _____

_____

For MRI or CT 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 a previous Myelogram? (If yes, when and where?) _____		
❑	❑	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		