ABERCROMBIE RADIOLOGICAL CONSULTANTS, INC.

LUMBAR SPINE
MRI AND CT HISTORY

ID# _____

PATIENT'S NAME_____DATE_____

SEX M_____ F_____ AGE _____ DOCTOR_____

WHAT COMPLAINTS OR SYMPTOMS LED YOU TO SEEK MEDICAL HELP? _____

_____

HOW LONG HAVE YOU HAD THESE SYMPTOMS? _____

DO YOU HAVE LOW BACK PAIN? YES _____ NO _____

IF YES, HOW LONG HAVE YOU HAD THIS? _____

DO YOU HAVE PAIN, NUMBNESS, OR TINGLING IN ANY OF THE FOLLOWING AREAS: PLEASE CHECK WHERE APPROPRIATE:

	RIGHT	LEFT
BUTTOCKS	_____	_____
FRONT OF THIGH	_____	_____
BACK OF THIGH	_____	_____
CALF	_____	_____
FOOT NEAR BIG TOE	_____	_____
FOOT NEAR SMALL TOE	_____	_____

DO YOU HAVE ANY WEAKNESS OF THE RIGHT LEG?	YES	NO
DO YOU HAVE ANY WEAKNESS OF THE LEFT LEG?	YES	NO
DO YOU HAVE ANY DIFFICULTY IN RAISING YOUR FOOT?	YES	NO
DO YOU HAVE ANY DIFFICULTY IN LOWERING YOUR FOOT?	YES	NO
DO YOU UNNATURALLY RETAIN URINE?	YES	NO
HAVE YOU HAD A MYELOGRAM?	YES	NO

IF YES, WHAT WERE THE RESULTS? _____

HAVE YOU HAD BACK SURGERY? YES NO

IF YES, DATE OF SURGERY? _____

IF YES, DO YOU KNOW THE LEVEL? L3-L4 L4-L5 L5-S1

PLEASE NOTE ANY OTHER SYMPTOMS RELATED TO YOUR BACK AND ANY RESULTS OF PREVIOUS STUDIES

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