

MRI Lumbar Questionnaire

Patient Name: _____ Birthdate: _____

What complaints or symptoms lead 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 pain? _____

Do you have pain, numbness, or tingling in any of the following areas?
Please check all areas applicable.

| | LEFT | RIGHT |
|---------------------|--------------------------|--------------------------|
| Buttocks | <input type="checkbox"/> | <input type="checkbox"/> |
| Front of thigh | <input type="checkbox"/> | <input type="checkbox"/> |
| Back of thigh | <input type="checkbox"/> | <input type="checkbox"/> |
| Calf | <input type="checkbox"/> | <input type="checkbox"/> |
| Foot near big toe | <input type="checkbox"/> | <input type="checkbox"/> |
| Foot near small toe | <input type="checkbox"/> | <input type="checkbox"/> |

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 raising your foot? Yes No

Do you have any difficulty lowering your foot? Yes No

Do you unnaturally retain urine? Yes No

Have you ever had a myelogram? Yes No

If yes, what were the results? _____

Have you had any back surgery? Yes No

If yes, what was the date of the surgery: _____

If you have had surgery on your lower back, do you know what the level was? L3-L4, L4-L5, L5-S1

Please note any other symptoms related to your back and any results of any previous studies performed on your back.
