NORTH DOVER RADIOLOGY

THORACIC SPINE MRI QUESTIONNAIRE

Name_____DOB_____AGE_____

What complaints or symptoms lead you to see your doctor?_____

_____

How long have you had these symptoms?_____

Have you ever had trauma or injury to your upper back?_____When?_____

If yes, please describe_____

Do you have back pain?_____For how long?_____

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

	LEFT	RIGHT
Buttocks	____	_____
Front of thigh	____	_____
Back of thigh	____	_____
Calf	____	_____
Foot near big toe	____	_____
Foot near small toe	____	_____

Do you have difficulty urinating?_____

Do you have weakness of the legs?_____ Left_____ Right_____

Do you have difficulty raising your foot?_____ Left_____ Right_____

Do you have difficulty lowering your foot?_____ Left_____ Right_____

Please list any other medical problems that you have, or have had in the past.

_____

_____:_____

Please list any and all medications you are currently taking.

_____

_____

Patient's Signature_____