



MIDDLETOWN MEDICAL IMAGING

LUMBAR/THORACIC SPINE CT/MR QUESTIONNAIRE

DATE _____

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 lower back? _____ When? _____

If you suspect trauma or injury to have caused your pain, please describe how it occurred: _____

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 _____