

**HIGH FIELD OPEN MRI PATIENT QUESTIONNAIRE**  
**MRI CERVICAL AND THORACIC SPINE**

Name: \_\_\_\_\_ Date \_\_\_\_\_

Do you have any history of cancer? If yes, please detail \_\_\_\_\_

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What complaints or symptoms led you to seek medical help? \_\_\_\_\_

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How long have you had these symptoms? \_\_\_\_\_

Do you have neck or arm pain? \_\_\_\_\_

If yes, for how long? \_\_\_\_\_

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

	<u>Right</u>	<u>Left</u>
Neck	_____	_____
Shoulder	_____	_____
Arm	_____	_____
Fingers	_____	_____

Do you have any weakness of the right arm or hand?    \_\_\_ YES    \_\_\_ NO

Do you have any weakness of the left arm or hand?    \_\_\_ YES    \_\_\_ NO

Do you have difficulty in raising your arm?    \_\_\_ YES    \_\_\_ NO

When you bend your neck, do you get a shock or sharp pain  
Radiating down your back and into your legs?    \_\_\_ YES    \_\_\_ NO

Have you had a myelogram? (an x-ray of the spine after an injection of air or a radiopaque substance)    \_\_\_ YES    \_\_\_ NO

If yes, what were the results? \_\_\_\_\_

Have you had neck surgery?    \_\_\_ YES    \_\_\_ NO

If yes, date of surgery \_\_\_\_\_

Do you know at which level?    C3-4 \_\_\_    C4-5 \_\_\_    C5-6 \_\_\_    C6-7 \_\_\_

Please note any other symptoms related to your neck \_\_\_\_\_

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