

**HIGH FIELD OPEN MRI PATIENT QUESTIONNAIRE  
MRI LUMBAR SPINE**

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

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

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, for how long? \_\_\_\_\_

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 weakness of the right leg? \_\_\_\_ YES \_\_\_\_ NO

Do you have weakness of the left leg? \_\_\_\_ YES \_\_\_\_ NO

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

Do you have difficulty in lowering your foot? \_\_\_\_ YES \_\_\_\_ NO

Do you unnaturally retain urine? \_\_\_\_ YES \_\_\_\_ NO

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

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

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

Do you know at which level? \_\_\_\_ L3-4 \_\_\_\_ L 4-5 \_\_\_\_ L5-S1

Please note any other symptoms related to your lower back and any results of previous studies

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_