Delaney Radiologists

MRI SPINE
PATIENT HISTORY

Date: _____

Delaney No. _____

Name: _____ Sex: M ❑ F ❑ Age: _____

PLEASE TRY TO ANSWER ALL QUESTIONS

What is your present complaint or problem?

_____

_____

About how long ago did it start? _____

Did you injure your back or neck? ..... Yes ❑ No ❑

Were any bones broken? ..... Yes ❑ No ❑

Did the injury occur at work? ..... Yes ❑ No ❑

Have you had any surgery on your back or neck? ..... Yes ❑ No ❑

When? _____ Where? _____

Have you had a recent related CT scan, MRI or Myelogram? ..... Yes ❑ No ❑

When? _____ Where? _____

What were you told it showed? _____

_____

Does anything make it worse? (Standing, Sitting, Lying Down, etc.) _____

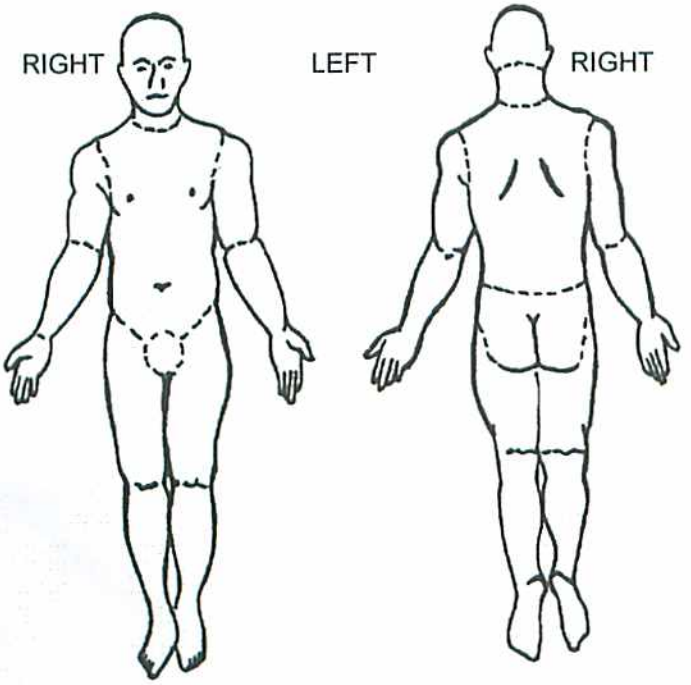
Do you have weakness? ..... Yes ❑ No ❑

Do you have numbness? ..... Yes ❑ No ❑

Have you had any bowel or bladder changes? ..... Yes ❑ No ❑

Do you have a history of cancer? ..... Yes ❑ No ❑

If yes, what type? _____



Please shade in the areas of pain or symptoms that has prompted this MRI.

Patient Signature _____

Date _____

Technologist Signature _____

Date _____