

## Eastern Radiologists, Inc. - Greenville MRI Spine Questionnaire

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

Age: \_\_\_\_\_ Birth date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Gender M F

Are you returning you your referring physician today? Y N Date of return: \_\_\_\_\_  
Briefly describe your condition and how long you have had these symptoms. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

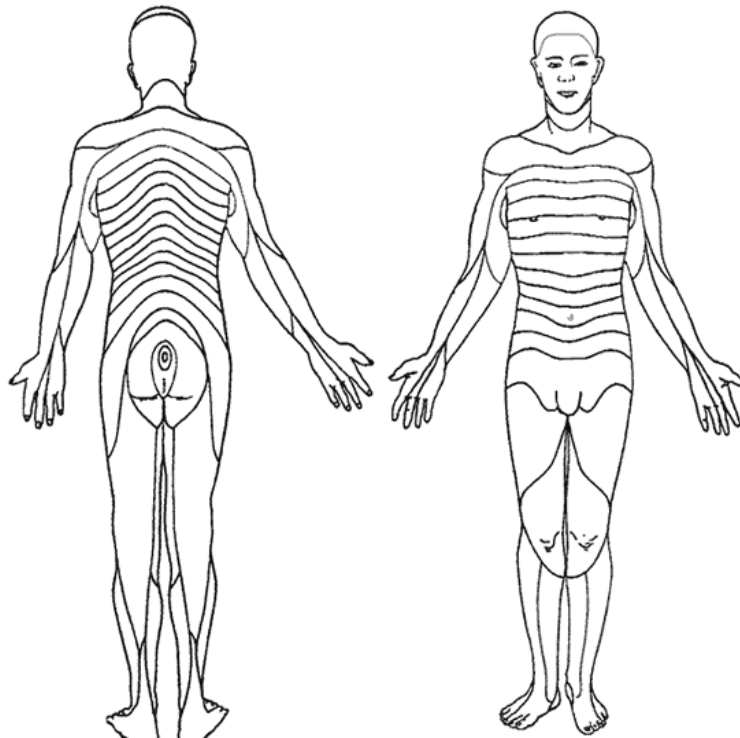
Have you had neck or back surgery? Y N Details/Dates: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you had any of the following performed on your spine? If so, please indicate when, where, and results.

TEST	When	Hosp/Imaging Center	Results
X-rays			
CT scan			
MRI scan			
Bone scan			
Steroid injection			

Please shade in areas of pain, weakness or numbness.

LEFT                      RIGHT                      RIGHT                      LEFT



Additional comments: \_\_\_\_\_