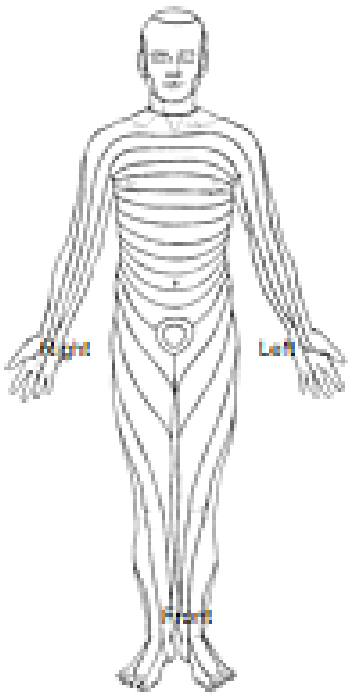
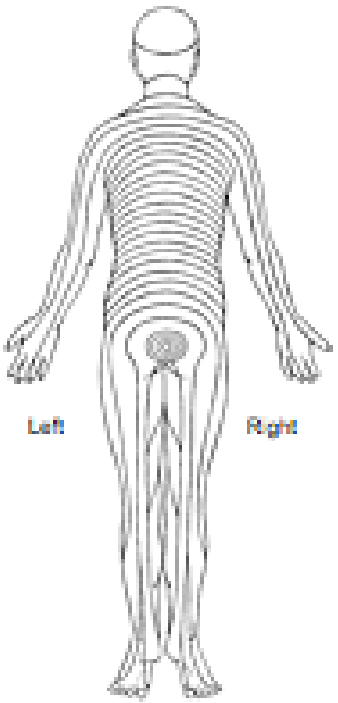
Pembina High-Field MRI

AKA Direct Medical Imaging LLC

P. 701-335-7742 F. 612-435-9211 E. info@pembinamri.com

Patient History Sheet: Spine





Name: _____ **Date of Exam** _____

Gender: ❑ Male ❑ Female **Date of Birth:** _____

Was the onset of your symptoms related to an injury? ❑ Yes ❑ No

If yes, how and when? _____

_____

Symptoms:

How long have you had your symptoms? _____

Please give a description of your symptoms (be thorough): _____

_____

Please check the area(s) affected below and shade affected area(s) to the left.

Headaches	❑ Yes	❑ No	
Neck pain	❑ Yes	❑ No	
Mid-back pain	❑ Yes	❑ No	
Lower-back pain	❑ Yes	❑ No	
Do you have bowel or bladder incontinence	❑ Yes	❑ No	
Any history of cancer	❑ Yes	❑ No	Type: _____

If yes, when was it diagnosed? _____

How was it treated? ❑ Radiation therapy ❑ Chemotherapy ❑ Surgery

If you experience pain, numbness or tingling, check the appropriate boxes below.
Please also shade the corresponding area(s) on the diagrams to the left.

Shoulder pain	❑ Left	❑ Right
Arm pain	❑ Left	❑ Right
Arm numbness or tingling	❑ Left	❑ Right
Arm weakness	❑ Left	❑ Right
Hand/finger numbness or tingling	❑ Left	❑ Right
Hand/finger weakness	❑ Left	❑ Right
Leg pain	❑ Left	❑ Right
Leg numbness or tingling	❑ Left	❑ Right
Leg weakness	❑ Left	❑ Right
Foot/toe pain	❑ Left	❑ Right
Foot/toe numbness or tingling	❑ Left	❑ Right

Have you ever had surgery on this specific part of your spine before? ❑ Yes ❑ No

If yes, when? _____ What was done? _____

Previous Spine Studies:

Bone scan:	❑ Yes ❑ No	Where: _____	Date: _____
X-Rays:	❑ Yes ❑ No	Where: _____	Date: _____
CT scan:	❑ Yes ❑ No	Where: _____	Date: _____
MRI scan:	❑ Yes ❑ No	Where: _____	Date: _____
Myelogram:	❑ Yes ❑ No	Where: _____	Date: _____