

**MRI PATIENT QUESTIONNAIRE
SPINE**

Name: _____ **Date:** _____

What problems are you having that led you to having this scan?

Do you have pain? _____ **If yes, where?** _____

Do you have weakness? _____ **If yes, where?** _____

Do you have numbness? _____ **If yes, where?** _____

Have you ever had spinal surgery? _____

If yes, what type & when? _____

Do you have any history of cancer? _____

Have you had any radiation or chemotherapy? _____

If yes, what type & when? _____
