SDMI STEINBERG DIAGNOSTIC

History Questionnaire
Advanced Spine Imaging

Patient Information Patient Number _____ *to be filled in by tech*

First Name _____ Last Name _____ Age _____

Reason for your Exam *(please describe in detail)*

_____

_____

_____

TECH NOTES: *(for internal use only)*

Contrast _____

Sedation _____

Notes _____

SYMPTOMS, Body *(circle all that apply)*

Neck Pain	Acute	Chronic	Due to Trauma
Mid Back Pain	Acute	Chronic	Due to Trauma
Low Back Pain	Acute	Chronic	Due to Trauma
Face Numbness	Right	Left	Bilateral
Face Weakness	Right	Left	Bilateral
Body Numbness	Right	Left	Bilateral
Body Pain	Right	Left	Bilateral

How long have you had the above symptoms:

_____

_____

_____

SYMPTOMS, Extremeties *(circle all that apply)*

Radiculopathy

Arm Numbness	Right	Left	Bilateral
Arm Pain	Right	Left	Bilateral
Leg Numbness	Right	Left	Bilateral
Leg Pain	Right	Left	Bilateral

Myelopathy

Arm Weakness	Right	Left	Bilateral
Leg Weakness	Right	Left	Bilateral
Limited Range of Motion?	NO	YES	

*If YES, list exact location:*_____

Have you ever been diagnosed with Diabetes? YES NO

Have you ever had Renal Failure / Dialysis? YES when:_____ NO

Is your problem related to an injury? NO _____ YES _____ *(if yes continue)*

Date of Injury _____ How were you injured *(circle one)* Car Accident Work Other

Describe Injury *(please be specific)* _____

_____

Have you ever been diagnosed with cancer? NO _____ YES _____ *(if yes continue)*

What type of cancer _____ Location _____ Date Diagnosed_____

Current Status *(please circle one)* Newly Diagnosed Recurrence Remission

Treatment *(please circle all that apply)* Surgery Radiation ChemoTherapy

Date of last Treatment _____

Has it spread? NO _____ YES _____ If Yes, Where _____

Is your visit today related to this cancer diagnosis NO _____ YES _____

Previous surgeries related to the affected area you are being seen for today. *(Please list specifically, what and when. Use back if extra space needed.)*

Procedure Description	Date

Previous imaging studies related to the affected area you are being seen for today. *(Please list specifically, what and when. Use back if extra space needed.)*

Procedure Description	Date