



LUMBAR SPINE CT QUESTIONNAIRE
Patient Information Form

NAME \_\_\_\_\_ DATE \_\_\_\_\_

What complaints or symptoms lead you to seek medical help? \_\_\_\_\_

How long have you had these symptoms: \_\_\_\_\_

Do you have low back pain? [ ] Yes [ ] No

If yes, for how long have you had this? \_\_\_\_\_

Do you have pain, numbness, or tingling in any of the following areas? Please check where appropriate.

Table with 3 columns: Symptom, Right, Left. Rows include: Buttocks, Front of thigh, Back of thigh, Calf, Foot near big toe, Foot near small toe.

Do you have any weakness of the right leg? Yes No

Do you have any weakness of the left leg? Yes No

Do you have difficulty in raising your foot? Yes No

Do you have difficulty in lowering your foot? Yes No

Do you unnaturally retain urine? Yes No

Have you had a Myelogram? Yes No

If yes, what were the results? \_\_\_\_\_

Have you had a previous CT? Yes No

If yes, what were the results? \_\_\_\_\_

Have you had back surgery? Yes No

If yes, date of surgery \_\_\_\_\_ If yes, do you know the level? (circle one) L3-L4 L4-L5 L5-S1

Please note any other symptoms related to your back and any results of previous studies \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ PT # \_\_\_\_\_ DATE: \_\_\_\_\_

FOR CT TECHNOLOGIST ONLY

BUN \_\_\_\_\_ (7 - 18)

Creatinine \_\_\_\_\_ (0.4 - 1.4)

No IV Contrast (Reason):    PROTOCOL    ALLERGIC    PT REFUSED    PHYSICIAN REQUEST    ELEVATED LABS

**IV CONTRAST:**    OPTIRAY 320    OPTIRAY 320    OPTIRAY 350    HAND INJECTED \_\_\_\_\_ CC/SEC    \_\_\_\_\_ SEC DELAY

ACCESSED BY \_\_\_\_\_    SITE:  Right  Left    Hand    Wrist    Forearm    Antecubital    Mediport    Existing IV Site

ORAL CONTRAST

RECTAL CONTRAST (AIR - GASTROGRAFIIN)

Additional Technologist Notes: \_\_\_\_\_

Metformin (Glucophage) Form Given to Patient: \_\_\_\_\_

- Pt. Uncooperative     Pt on respirator     Pt In restraints     Pt moving     Pt very large     Pt being held
- Unable to hold breath     Unable to raise arms up     Pt unresponsive

RADIOLOGIST NAME (If consulted about case): \_\_\_\_\_

SCAN ID: \_\_\_\_\_    DISC # \_\_\_\_\_