



MRI EXTREMITY (JOINT) QUESTIONNAIRE

PATIENT NAME _____

DATE _____ DATE OF BIRTH _____

What joint/area are we scanning today? _____ Right () Left ()

Do you have pain? Yes () No ()

Where is your pain? _____

What were you doing when the pain started (was there a specific injury)? _____

How long have you had the pain (date of injury)? _____

Do you have:

Locking? Yes () No ()

Instability/joint gives out? Yes () No ()

Poor range of motion? Yes () No ()

Other symptoms? Yes () No () If Yes, explain _____

Have you had arthroscopy or surgery in the area we are scanning? ____ Yes ____ No

If yes, when and what did they do? _____

Do you have any other medical conditions that may be related to your problem? _____

Have you had any other previous studies for this problem?

MRI Yes() No() Date ___/___/___ Where? _____

CT Yes() No() Date ___/___/___ Where? _____

X-Ray Yes() No() Date ___/___/___ Where? _____

Bone Scan Yes() No() Date ___/___/___ Where? _____