MRI EXTREMITY (NON-JOINT) QUESTIONNAIRE

PATIENT NAME ____

DATE__________________________ DATE OF BIRTH_______________________

What is your present complaint or problem? ____

____

How long ago did these symptoms first appear?____

What were you doing when the symptoms started (was there a specific injury)?______________________________

____

Do you have:

Pain? Yes ( ) No ( ) Where?______________________________

A Lump or Mass? Yes ( ) No ( ) Where?______________________________

Cancer? Yes ( ) No ( ) Where?______________________________

Other symptoms? Yes ( ) No ( ) If Yes, explain______________________________

Osteoarthritis? Yes ( ) No ( )

Rheumatoid Arthritis? Yes ( ) No ( )

Lupus? Yes ( ) No ( )

Sickle Cell Anemia? Yes ( ) No ( )

Are you presently taking steroid medication? Yes ( ) No ( )

If Yes, explain____

Have you had 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?______________________________