

MRI PATIENT QUESTIONNAIRE

EXTREMITIES

NAME: _____ DATE: _____

WHAT PROBLEMS ARE YOU HAVING THAT LED YOU TO HAVE THIS SCAN?

DID YOU INJURE YOURSELF? _____ WHEN? _____

DO YOU HAVE PAIN? _____

WHERE? _____

DO YOU HAVE LOCKING OF THE JOINT?

YES _____ NO _____

HAVE YOU HAD ANY PRIOR SURGERY RELATED TO YOUR CURRENT PROBLEM?

YES _____ NO _____ WHEN _____

IF YES, WHAT TYPE? _____

ANY HISTORY OF CANCER, RADIATION, OR CHEMOTHERAPY?

IF YES, WHAT TYPE? _____

WHEN? _____