

MRI PATIENT QUESTIONNAIRE

KNEE

NAME: _____ DATE: _____

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

DID YOU FALL OR INJURE YOURSELF? _____

WHERE DO YOU HAVE PAIN?

LEFT KNEE _____ RIGHT KNEE _____

MEDIAL (INSIDE) _____ LATERAL (OUTSIDE) _____

ANTERIOR (FRONT) _____ POSTERIOR (BACK) _____

DO YOU HAVING LOCKING OF THE JOINT? _____

HAVE YOU HAD SURGERY TO THE KNEE? _____

WHAT TYPE? _____

WHEN? _____

ANY HISTORY OF CANCER, RADIATION, CHEMOTHERAPY? _____

WHAT TYPE? _____