

MRI Patient Clinical History
Musculoskeletal

Name: _____ Date: _____

Please indicate if these symptoms are the result of the following:

Auto Accident ()

Injury ()

Illness ()

When did your symptoms start or accident happen: _____

Please answer all questions that pertain to today's examination:

Front View

Back View

YES NO Do you experience or have the following?

Right

Left

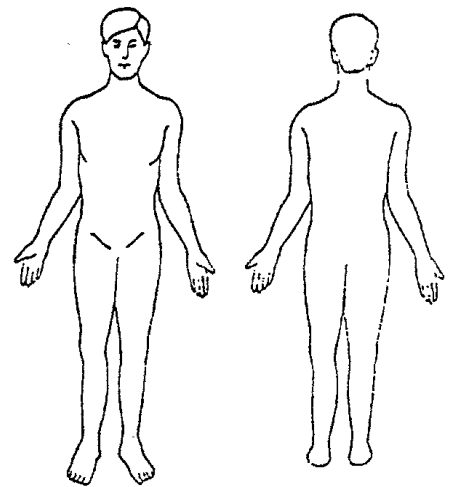
Left

Right

() () Shoulder Pain Right Left
 () () Arm Pain Right Left
 () () Elbow Pain Right Left
 () () Wrist / Hand Pain Right Left

() () Hip Pain Right Left
 () () Leg Pain Right Left
 () () Knee Pain Right Left
 () () Ankle / Foot Pain Right Left

() () Swelling, mass or lump in this area
 () () Stiffness of joint
 () () Cracking or Popping of joint
 () () Decrease in range of movement
 () () History of dislocations



Other symptoms or complaints: _____

() () Have you had previous surgery to this body location?

Procedure: _____ When? _____

() () Have you had any prior X-rays, CT Scan, Ultrasound or Nuclear Medicine exams for this area?

Where: _____

() () Have you had Cancer? Type: _____

What was done? Surgery Chemotherapy Radiation Therapy

Date of Surgery: _____ Date of Therapy: _____