MOLECULAR imaging

MRI Patient Clinical History
Musculoskeletal

Name:____ Date:____________________

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

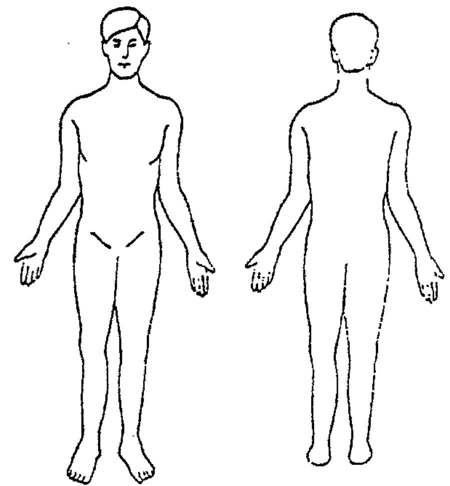
Auto Accident ( ) Injury ( ) Illness ( )

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?		
( )	( )	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		

Right Left Left Right



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:_________________