HAZLETON IMAGING

Date of Birth:

Referring Physician:

Extremity MRI Questionnaire

1. Extremity to be examined. (PLEASE CIRCLE)

HIP	WRIST
THIGH	FOREARM
LOWER LEG	ELBOW
ANKLE	HAND
FOOT	JAW

2. Which side? ☐ Left ☐ Right

3. Symptoms / Complaints. (PLEASE CIRCLE ALL THAT APPLY)

PAIN	FLUID IN JOINT
MASS	REDNESS
SWELLING	LOCKING
CLICKING	LIMITED MOVEMENT

4. How long have you had these symptoms? _____

5. Have you undergone any therapy? (i.e., physical therapy / bed rest)

What type _____

Duration _____

Outcome _____

6. Please give a brief description of the incident

_____

7. Any other examinations of the AFFECTED AREA?

X-Ray ☐ Yes CT ☐ Yes MRI ☐ Yes

Performed at what facility? _____

Approximately what date? _____

I attest that the answers I have provided to questions on this form are correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information on this form.

Signature (Parent or Guardian)

_____

Date Signed: _____