



ORTHOPEDIC MRI QUESTIONNAIRE

Delaney #: _____

Name: _____

Phone: _____ DOB: _____ Sex M F

Date of Exam: _____ Referring Physician: _____

Please fill out the questions below to the best of your ability. Your answers will ensure that you receive the best possible MRI evaluation for your particular situation.

What part of your body is being examined? _____

What is your current complaint? _____

Did you have a specific injury? Yes No

If Yes, when and how did this occur? _____

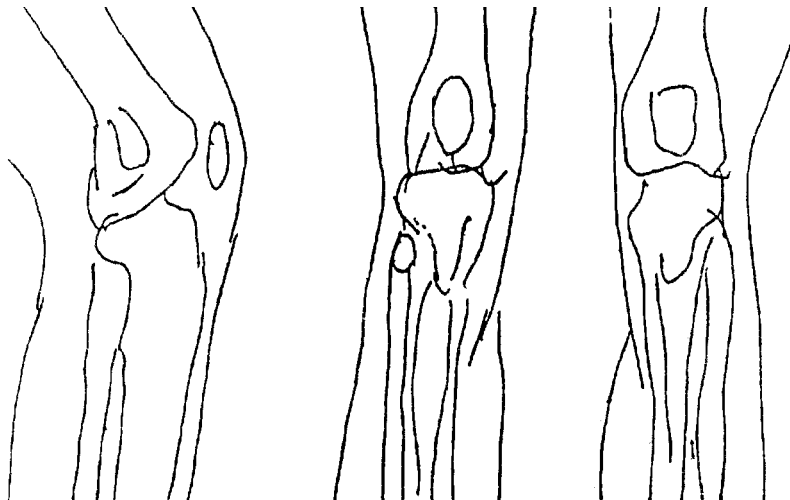
If No, when and how did you first notice this problem? _____

Have you ever had surgery or arthroscopy of the part being scanned? Yes No

If Yes, when and what surgery was performed? _____

What particular activities exacerbate your symptoms? _____

Do you have any other major medical problems (for example, Anemia, Cancer, Sickle Cell Disease, Rheumatoid Arthritis, Diabetes)? _____



RIGHT

LEFT

For KNEES, please draw an arrow to the point of maximal pain or area of concern.

Patient Signature _____

Date _____

Technologist Signature _____

Date _____