

BASIC MEDICAL INFORMATION FOR ORTHOPEDIC PROBLEMS

Please fill out this form to the best of your ability. If you do not know exact dates, just estimate.
This information is very important and will be reviewed during interpretation of your MRI.

NAME: _____ SEX: _____ AGE: _____

HEIGHT: _____ WEIGHT: _____ OCCUPATION: _____

DOMINANT HAND: _____

Questions

Please write your answers below

What orthopedic problem are we evaluating
with today's MRI?

When did the problem first occur?

Was this the result of an accident or repetitive
stress? If accident, what is the date of injury?
Briefly describe the accident.

Where is the pain located exactly?
(Example: front, back, inside, or outside of joint)

Does the pain radiate anywhere?
(Example: down an arm or leg)

If you have pain, please describe it and rate it from
A scale of 1-10 with 0 meaning "no pain"
and 10 meaning "worst ever".

What relieves the symptoms?

Have you had a similar problem before? When?

What radiology tests have you had for this problem?

Have you had arthroscopy or surgery?
If yes, when and where?

What other major medical conditions do you have?
(Example: cancer, anemia, and osteoporosis)

Any other comments that you feel might be helpful?
