EXTREMITY IMAGING

Patient Name_____ DOB__ /___/___ Weight ____Height____

Address_____ SS#_____-_____-_____

Phone_____ Cell_____ Work_____

What Body part are you having an MRI of? _____RT ☐ LT ☐

Please circle the appropriate answer for the following :

Have you had an injury? YES ☐ NO ☐ if yes, Date of injury_____

How did your injury occur? _____

Have you had joint surgery? YES ☐ NO ☐ if yes, Date _____

Have you had any other related studies ? YES ☐ NO ☐
(X-rays, CT scans, Bone scans, etc…)
if yes, When and Where were they done?_____
_____

Do you have a history of cancer YES ☐ NO ☐ Radiation or Chemotherapy
If yes, please explain_____

Please EXPLAIN the location of pain and/or movement that causes pain
_____
_____
_____
_____

_____ _____ ____/____/____
Signature of Person Completing Form Relationship to Patient Date