Dynamic Medical Imaging

Stand-up MRI
CT
Ultrasound
X-Ray

BONE AND JOINT CT/MR QUESTIONNAIRE

Today's Date:____________________

Name_________________________DOB______________________AGE_____

What complaints or symptoms lead you to see your doctor?_______________________

____

Have you had trauma or injury to this area: (Circle) Yes or No

If you suspect trauma or injury to have caused your pain, please describe how it occurred

____

____.

How long have you had these symptoms?_____________________________________

Regarding the area for examination today, have you ever had:

	YES	NO	WHEN
Fracture	_____	_____	___________
Trauma/Injury	_____	_____	___________
Dislocation	_____	_____	___________
Arthrogram	_____	_____	___________
Arthroscope	_____	_____	___________

Do you have a history of…

Rheumatoid Arthritis	_____	_____
Ankylosing Spondylitis	_____	_____
Osteoarthritis	_____	_____
Gout	_____	_____
Psoriasis	_____	_____
Reiter's Syndrome	_____	_____
Hemophilia	_____	_____

Please list any other medical problems that you have, or have had in the past:

____

____

____

Please list any and all medications you are currently taking:

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____

____

Patient's Signature____