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:  