FOOT/LEG/ANKLE
MRI QUESTIONNAIRE

PATIENT WEIGHT__________ PATIENT HEIGHT__________

INJURY
Work-related Injury _____ Yes _____ No
Motor Vehicle Accident _____ Yes _____ No
Sports Injury _____ Yes _____ No
Date of Injury ____________________________________________
Describe Injury __________________________________________

SYMPTOMS
Pain
____ Top of Foot
____ Bottom of Foot
____ Inside Foot
____ Outside Foot
____ Swelling
____ Bruising
____ Stiffness
____ Feels best in A.M.
____ Feels worst in A.M.
____ Feels worst in P.M.
____ Feels better after warming up
____ Decreased strength (describe)
____ Numbing/shooting or burning sensation
____ Pain with weight bearing
____ Pain with specific activity (describe)
____ Mass
____ Fever/chills

How long have you had the above symptoms?________________________

_____ History of medical disease (Parkinson’s Disease, Arthritis, etc.)
   Please describe________________________________________________
_____ History of cancer (please indicate primary cancer)
   Please describe________________________________________________

PREVIOUS STUDIES PERTAINING TO CURRENT PROBLEM
X-Rays Yes No Where_____________ Date__________
CT Scan Yes No Where_____________ Date__________
MRI Scan Yes No Where_____________ Date__________
Surgery/Arthroscopy
____ Yes No Where_____________ Date__________
What was done? (please specify)____________________________________

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Technologist Use: Technologist _________________________ Date _______________
Contrast: __________cc of ____________________(type) injected into __________(area).
Notes/Complications
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________