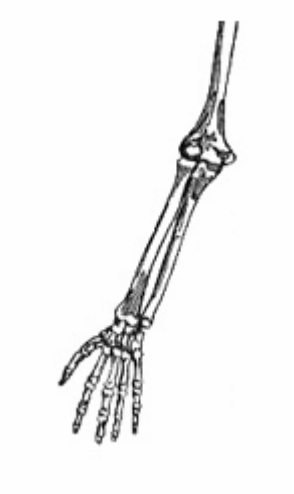
Please indicate below where pain is located.

HAND/WRIST/ARM 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 Hand _____Little Finger Side of Forearm

_____Palm of Hand _____Thumb Side of Forearm

_____ Swelling_____

_____ Bruising_____

_____ Decreased strength (describe)_____

_____ Numbness (describe)_____

_____ Shooting/burning sensation (describe)_____

_____ Clicking/popping sensation (describe)_____

_____ 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)_____

****

Technologist Use: **Technologist** _____ **Date** _____

Contrast: _____cc of _____ (type) injected into _____ (area).

Notes/Complications

_____

_____

_____

_____

_____