ADVANTAGE+ MRI
Excellence in High Field Imaging

MRI Patient Clinical History
Musculoskeletal

Name: _____ Date: _____

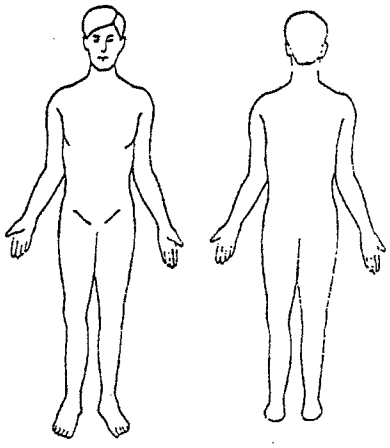
Please indicate if these symptoms are the result of the following:

Auto Accident ( ) **Personal Injury** Other than auto accident ( ) **Work Injury** ( ) **Illness** ( )

When did the accident happen (date): _____
How did this injury occur? (Describe what happened) _____
When did your symptoms begin: _____

Please answer all questions that pertain to today's examination.

YES	NO	Do you experience or have the following?		
( )	( )	Shoulder Pain	Right	Left
( )	( )	Arm Pain	Right	Left
( )	( )	Elbow Pain	Right	Left
( )	( )	Wrist / Hand Pain	Right	Left
( )	( )	Hip Pain	Right	Left
( )	( )	Leg Pain	Right	Left
( )	( )	Knee Pain	Right	Left
( )	( )	Ankle / Heel Pain	Right	Left
( )	( )	Forefoot Pain	Right	Left



( ) ( ) Swelling, mass or lump in this area
( ) ( ) Stiffness of joint
( ) ( ) Cracking or Popping of joint
( ) ( ) Decrease in range of movement
( ) ( ) History of dislocations

Other symptoms or complaints: _____

( ) ( ) Previous surgery to this body location

Procedure: _____ When? _____

( ) ( ) Have you had any prior X-rays, CT scan, Ultrasound or Nuclear Medicine exams **for this area**?

What Facility: _____

( ) ( ) Have you had cancer? Type: _____

What was done? Surgery Chemotherapy Radiation Therapy

Date of Surgery: _____ Date of therapy: _____

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the MR procedure that I am about to undergo.

Signature: _____ Date: _____