



MRI MUSCULOSKELETAL

Name \_\_\_\_\_ Date \_\_\_\_\_

Age \_\_\_\_\_ Weight \_\_\_\_\_

Type of exam \_\_\_\_\_

Please give a brief description of your symptoms related to the area to be scanned:

\_\_\_\_\_  
\_\_\_\_\_

History of fracture/dislocation? Yes \_\_\_ No \_\_\_  
If yes, give location, date of injury and treatment.

\_\_\_\_\_  
\_\_\_\_\_

History of Cancer? Yes \_\_\_ No \_\_\_  
If yes, give location, treatment.

\_\_\_\_\_  
\_\_\_\_\_

History of Arthritis? Yes \_\_\_ No \_\_\_  
If yes, give location and treatment.

\_\_\_\_\_  
\_\_\_\_\_

Have you had any Cortisone injections into the affected joint? Yes \_\_\_ No \_\_\_  
If yes, which joint? \_\_\_\_\_

Have you had any surgery on the affected joint? Yes \_\_\_ No \_\_\_  
If yes, when? \_\_\_\_\_

Type of operation (if known) \_\_\_\_\_

Prior scans (for the area being scanned today):

CT	Yes ___ No ___	When _____	Where _____
MRI	Yes ___ No ___	When _____	Where _____
X-ray	Yes ___ No ___	When _____	Where _____
Nuc medicine	Yes ___ No ___	When _____	Where _____
Arthrogram	Yes ___ No ___	When _____	Where _____

Technologist \_\_\_\_\_