Imaging

MRI Musculoskeletal and Spine Questionnaire

Salem Health® Hospitals & Clinics

Name: _____ Date: _____

**** PLEASE ANSWER THE FOLLOWING QUESTIONS COMPLETELY ****

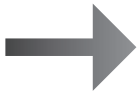
1. Please describe the reason for this examination, as YOU understand it (e.g. pain, lump, injury, etc. Please do not simply sate "doctor's orders."

   _____

   _____

   _____

   _____

2. ***If scan is for pain or lump, mark location on the reverse side of this form.*** 
3. If for an injury:

   On the job injury? ☐ Yes ☐ No How were you injured? _____

   Sports injury? ☐ Yes ☐ No What sport? _____

   Motor vehicle accident? ☐ Yes ☐ No

   Date of injury: _____
4. Have you ever had a fracture in the body part to be scanned? ☐ Yes ☐ No date: _____

   Have you ever had surgery in the body part to be scanned? ☐ Yes ☐ No date: _____
5. Do you have diabetes? ☐ Yes ☐ No
6. Have you had a bone infection? ☐ No If yes, date: _____
7. Have you had cancer? ☐ No If yes, date: _____

   Type of cancer: _____

   Cancer surgery: ☐ Yes ☐ No If yes, date: _____

   Chemotherapy: ☐ Yes ☐ No Last treatment: _____

   Radiation therapy: ☐ Yes ☐ No Last treatment: _____
8. Have you had a MRI or CT scan of this body part before? ☐ Yes ☐ No

   If yes, date: _____ Location: _____
9. Have you had x-rays of this body part before? ☐ Yes ☐ No

   If yes, date: _____ Location: _____
10. Do you have any allergies? ☐ Yes ☐ No If yes, what? _____

PATIENT LABEL

DSC 409480 (10/16)

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