iCare Diagnostic Imaging, LLC
2781 Freeway Blvd
Suite 160
Brooklyn Center, MN 55430

FOOT/LEG/ANKLE MRI QUESTIONNAIRE

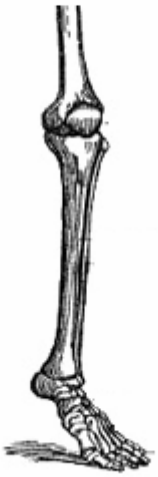
PATIENT WEIGHT_____**PATIENT HEIGHT**_____

INJURY

Work-related Injury	_____ Yes	_____ No
Motor Vehicle Accident	_____ Yes	_____ No
Sports Injury	_____ Yes	_____ No

Date of Injury_____
Describe Injury_____

Please indicate below where pain is located.



SYMPTOMS

_____ Pain **Foot** **Leg** **Ankle**

_____Top of Foot	_____Front	_____Outside Heel
_____Bottom of Foot	_____Back	_____Central Heel
_____Inside Foot	_____Inside	_____Inside Heel
_____Outside Foot	_____Outside	

_____ 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

_____
_____
_____
_____
_____
_____