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

HIP/THIGH MRI QUESTIONNAIRE

PATIENT WEIGHT_____PATIENT HEIGHT_____

INJURY

Work-related Injury _____ Yes _____ No

Motor Vehicle Accident _____ Yes _____ No

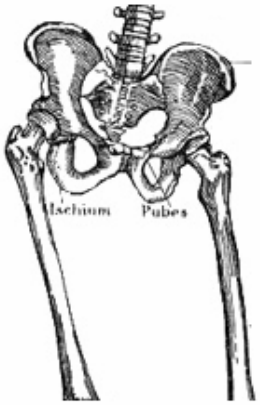
Sports Injury _____ Yes _____ No

Date of Injury_____

Describe Injury_____

SYMPTOMS

Please indicate below where pain is located.



_____ Pain _____Front/Groin _____Back/Buttock

_____Front Thigh _____Back Thigh

_____Outside Thigh _____Inside Thigh

_____Snapping hip _____Hip

_____Outside/Gr. Trochanter

_____ Swelling_____

_____ Catching sensation_____

_____ Weakness_____

_____ Painful when lying on affected side_____

_____ Pain with weight bearing_____

_____ Numbing/burning sensation_____

_____ 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_____
Myelogram	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

_____

_____

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