iCare Diagnostic Imaging, LLC
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KNEE
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 _____ Front _____ Back
_____ Outside _____ Inside

_____ Swelling _____ Immediate _____ Gradual

_____ Fluid drained Any blood?_____ Date_____

_____ Catching sensation_____

_____ True locking_____

_____ Giving way_____

_____ Weakness_____

_____ Difficulty extending knee fully_____

_____ Difficulty bending knee fully_____

_____ 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

_____

_____

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