



Advanced Imaging Newport Coast

PATIENT QUESTIONNAIRE

MRI WRIST

Please complete the following questions as best as you can

NAME : _____ DATE : _____

Do you have :

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Dull Ache _____ Sharp Pain _____ Grinding _____ | | |
| 2. Have you had surgery on this area ? | <input type="checkbox"/> | <input type="checkbox"/> |
| What was done ? _____ | | |
| When ? _____ | | |
| 3. How long have you had this problem ? _____ | | |
| 4. How did the problem occur ? | | |
| <input type="checkbox"/> Accident <input type="checkbox"/> Lifting <input type="checkbox"/> Fall | | |
| <input type="checkbox"/> Surgery <input type="checkbox"/> Illness <input type="checkbox"/> Other _____ | | |
| 5. Do you have limited range of motion ? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have weakness or instability ? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you have swelling on the area ? | <input type="checkbox"/> | <input type="checkbox"/> |