

Diagnostic Radiology Department

Symptom Summary: Extremity

Patient Name:		Date:	
Age:	Weight:lbs.		
Body part to be examined:	:		
Please check below the sy	mptoms that prompted your ph	ysician to order this MRI exam:	
pain	☐ swelling	☐ clicking	
locking	☐ giving way	☐ limted motion	
lacksquare fluid in joint	☐ mass lump	other	
How long have you had th	ese symptoms?		
Are they a result of an inju	ary or accident?	no no	
Date of injury:	///		
Explain:			
Have you had prior surger	y to this area?	n o	
Date of surgery: _	///		
Explain:			
Have you ever been diagno	osed with cancer?	no no	
Date of diagnosis:	///		
What part of the b	ody?		
Have you had radiation?	☐ yes ☐ no Da	te of last treatment://	
Have you had chemother	apy? 🗖 yes 🗖 no	Date of last treatment://	
Have you had a previous M	MRI exam on this area? \Box y	ves \square no	
☐ Lahey ☐ O	ther facility		