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

# HAND/WRIST/ARM MRI QUESTIONNAIRE

**PATIENT WEIGHT_____PATIENT HEIGHT_____**

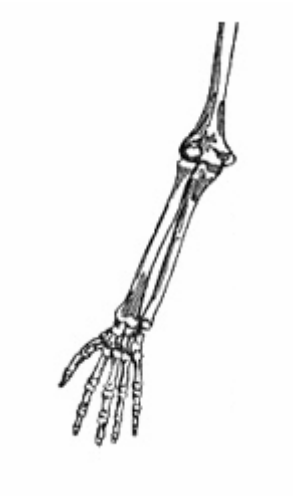
**INJURY**

Work-related Injury _____ Yes _____ No

Motor Vehicle _____ Yes _____ No

Sports Injury _____ Yes _____ No

Please indicate below where pain is located.



Date of Injury_____

Describe Injury_____

**SYMPTOMS**

_____ Pain _____Top of Hand _____Little Finger Side of Forearm

_____Palm of Hand _____Thumb Side of Forearm

_____ Swelling_____

_____ Bruising_____

_____ Decreased strength (describe)_____

_____ Numbness (describe)_____

_____ Shooting/burning sensation (describe)_____

_____ Clicking/popping sensation (describe)_____

_____ 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)_____

**********

**Technologist Use:** **Technologist** _____ **Date** _____

*Contrast:* _____cc of _____ (type) injected into _____ (area).

**Notes/Complications**

_____

_____

_____

_____

_____