

# **MRI Patient Clinical History**

# **Pelvis/Lower Extremity**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

What area is being imaged with MRI today? Pelvis Hip Thigh/Hamstring Calf/Shin Other: \_\_\_\_\_

Describe the symptoms that you are having in this area (pain, numbness, tingling, weakness, etc.): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How long have you had these symptoms, and how often do they occur? \_\_\_\_\_

\_\_\_\_\_

Are these symptoms related to a prior injury or surgery? If yes, then please describe: \_\_\_\_\_

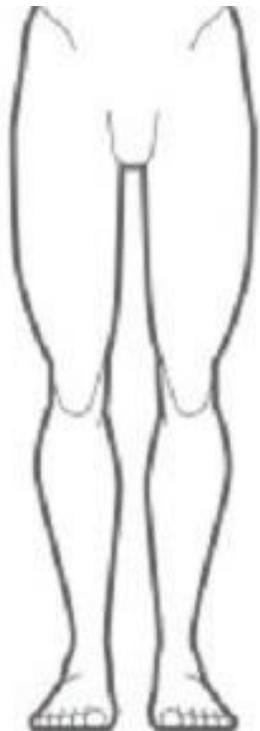
\_\_\_\_\_

Has this area been imaged before? \_\_\_\_\_

Have you ever had surgery or other procedure in this area? \_\_\_\_\_

Please use the diagram and space below to detail your symptoms

**Front**



**Back**

