

# **MRI Patient Clinical History**

# **Upper Extremity**

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

What area of your body is being imaged with MRI today? Bicep Triceps Elbow Forearm 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

