Advanced Medical Imaging
Bozeman Health & Intercity Radiology

905 Highland Blvd., Suite 4100
Bozeman, MT 59715
Phone: (406) 414-5200
Fax: (406) 414-5205
Scheduling: (406) 414-5201

MRI EXTREMITY QUESTIONNAIRE

NAME ______________________________ DATE ____________ AGE _____________

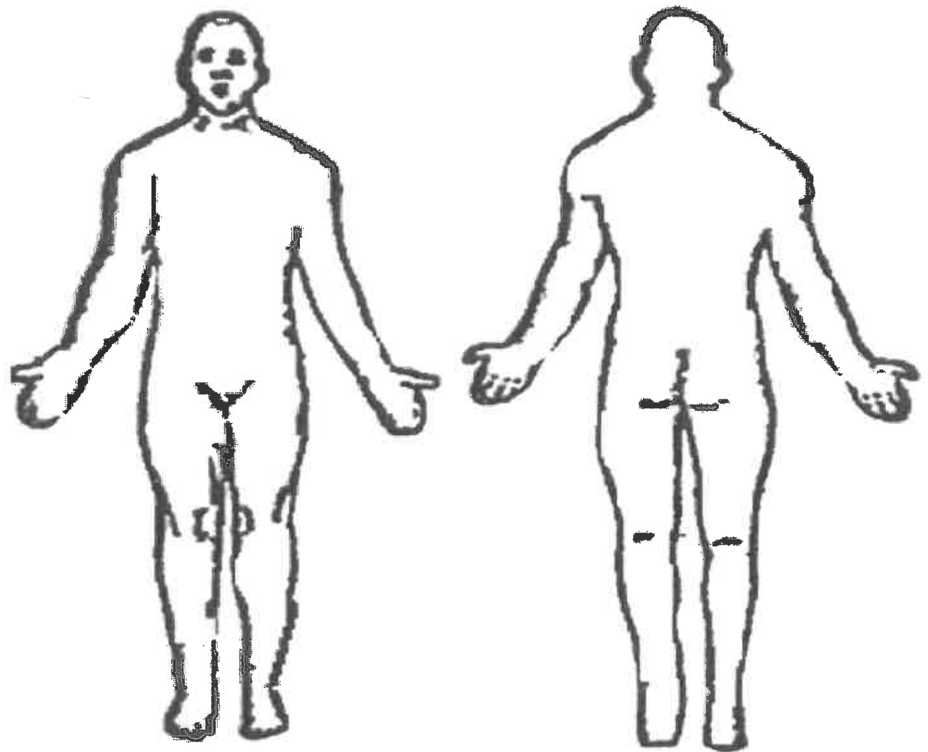
PLEASE CIRCLE THE APPROPRIATE RESPONSES

1. Have you had surgery to this region?

   If so, When___________________________

2. Do you have
   A. Pain?
   B. Numbness, tingling?
   C. Weakness?

3. Please identify the location of your symptoms in the adjacent diagram.



4. How long have your symptoms been present

   A. Days? C. Months?
   B. Weeks? D. Years?

5. Are your symptoms
   A. Getting better?
   B. Staying the same?
   C. Getting worse?

6. Have you had previous X-rays of this region?

   Where were they performed:___________________________

7. Additional comments you would like to make? ______________________________

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