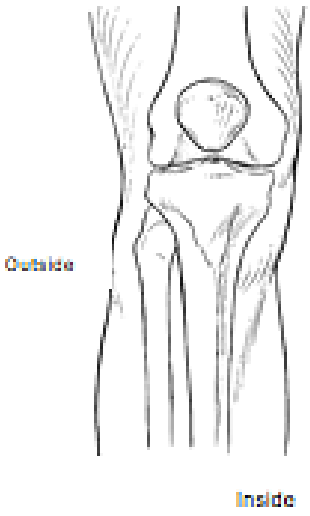
Pembina High-Field MRI

AKA Direct Medical Imaging LLC

P. 701-335-7742 F. 612-435-9211 E. info@pembinamri.com

Patient History Sheet: Knee

Date of Exam: _____



Name: _____ **Date of Birth:** _____

Which extremity? ❑ Right ❑ Left **Is this from an injury?** ❑ Yes ❑ No

Date of injury: _____

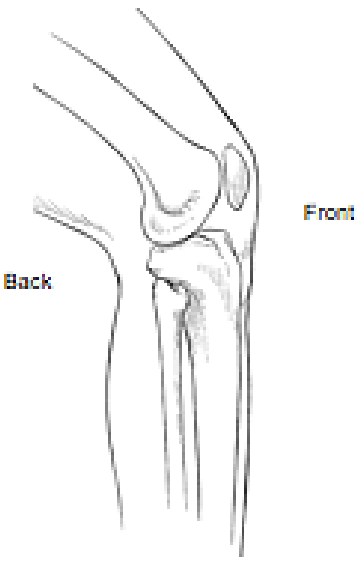
Describe injury: _____

_____

Symptoms:

How long have you had your symptoms? _____

Please check the area(s) affected below and shade affected area(s) to the left.



	❑ Front	❑ Back	❑ Inside	❑ Outside
Pain			❑ Yes ❑ No	
Swelling			❑ Yes ❑ No	
Weakness			❑ Yes ❑ No	
Catching sensations			❑ Yes ❑ No	
Giving way			❑ Yes ❑ No	
Mass/lump			❑ Yes ❑ No	
Fever/chills			❑ Yes ❑ No	
Difficulty straightening the knee fully			❑ Yes ❑ No	
Difficulty bending the knee fully			❑ Yes ❑ No	
Difficulty with stairs			❑ Yes ❑ No	
Any history of cancer			❑ Yes ❑ No	Type: _____

Any plain knee X-Rays taken?

❑ Yes ❑ No **Date of X-Rays:** _____

Site of X-Rays: _____

Findings: _____

Any injections done?

❑ Yes ❑ No **Date of injection:** _____

Site of injection: _____

Any relief from the injection?

❑ Yes ❑ No

Any arthroscopic or open knee surgery on this extremity?

❑ Yes ❑ No **Date of surgery:** _____

What was done? _____

Where was it done? _____