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? ____