St. Joseph Hospital MRI
Spine Survey/ Total Spine Questionnaire

PATIENT LABEL

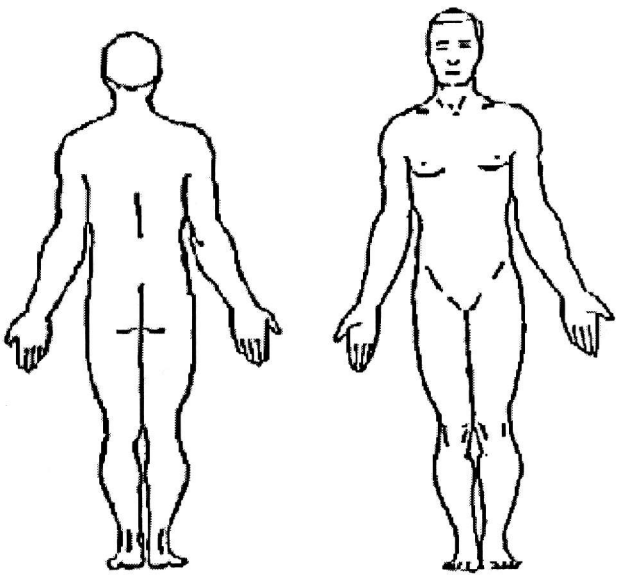
Circle the appropriate response(s)

Do you have?			**If yes, where?**					
PAIN:	Yes	No	Left	Right	Legs	Arms	Neck	Back
NUMBNESS:	Yes	No	Left	Right	Legs	Arms	Neck	Back
TINGLING:	Yes	No	Left	Right	Legs	Arms	Neck	Back
WEAKNESS:	Yes	No	Left	Right	Legs	Arms	Neck	Back

How long have you had these symptoms?

_____

Please shade in area(s) of Pain



BACK FRONT

Are your symptoms the result of an accident or injury?

Yes No

If Yes, briefly describe:_____
_____

Do you take medication for the pain? Yes No

What kind?_____
How often?_____
Does the medicine help?_____

Have you ever had surgery on your Cervical, Thoracic or Lumbar Spine? Yes No

If Yes, when and where?_____
Type of surgery?_____
Did the surgery relieve the pain? Yes No
If Yes, has the same pain now reoccurred? Yes No

Have you even had a CT scan, MRI or Myelogram of your back or spine? Yes No

If yes, which exam?_____
Where?_____ When?_____

Do you have a personal history of Cancer? Yes No

If yes, what type?_____ When were you diagnosed?_____

St. Joseph Hospital MRI
Extremity Questionnaire

PATIENT LABEL

Circle appropriate response(s)

Extremity to be studied:	SHOULDER	UPPER ARM	ELBOW
	FOREARM	WRIST	HAND
	HIP	THIGH	KNEE
	LOWER LEG	ANKLE	FOOT
Which side:	RIGHT	LEFT	
What are your symptoms:	PAIN	SWELLING	BUMP
	CLICKING	LOCKING	GIVES OUT
	REDNESS	BRUISING	LIMITED MOTION

Duration of symptoms: _____ DAYS _____WEEKS _____MONTHS _____YEARS

Have you ever had surgery on this extremity? YES NO

Explain_____

Did you have an injury that caused your symptoms? YES NO

Explain_____

Have you had an X-Ray on this extremity? YES NO

If yes, where?_____

St. Joseph Hospital MRI- Breast Symptom Questionnaire

Patient Name _____

MR # _____

Age _____

Referring Physician _____

Date of Examination _____

1 Do you have any breast symptoms? Discharge, lump, pain? Y N

2 Does any relative have a history of breast cancer? Age? Y N

_____Mother _____Sister _____Grandmother _____Other

3 Are you still menstruating? Y N

If yes, date of last menstrual period: _____

If no, year of last menstrual period: _____

4 Do you use estrogen replacement therapy? Y N

If yes, for how long: _____

5 Could you be pregnant? Y N

6 Have you ever had prior breast surgery? Y N

If yes, what type?

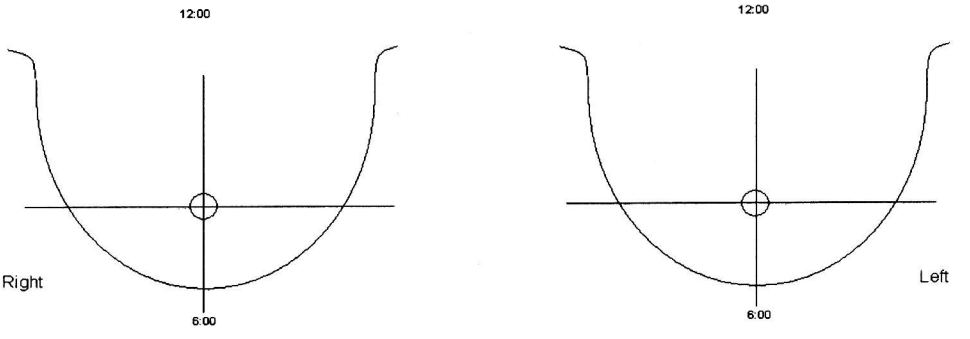
_____Benign Biopsy Right Left
_____Lumpectomy Right Left
_____Mastectomy Right Left

7 Have you ever had radiation therapy to the breast? Y N

If yes, what side? Right Left

8 When was your last mammogram? Date _____

9 Diagram scars of physical findings:



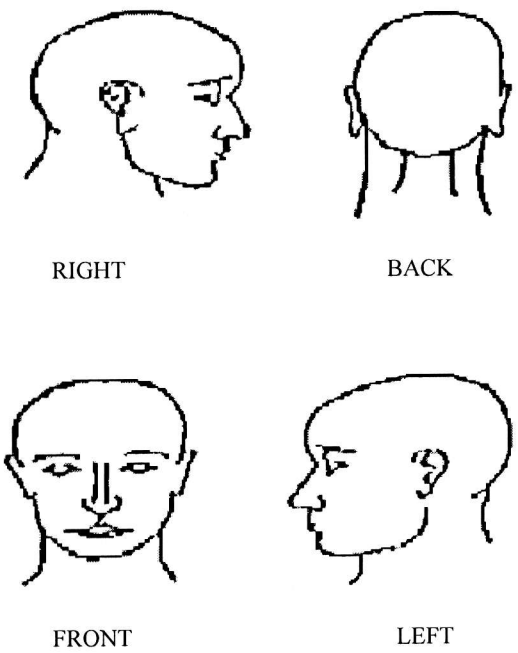
St. Joseph Hospital MRI
Brain Questionnaire

PATIENT LABEL

Please Circle Appropriate Answers:

RIGHT / LEFT HANDED	RIGHT	LEFT
HEADACHES	YES	NO
MEMORY LOSS	YES	NO
DIZZINESS	YES	NO
UNCOORDINATED	YES	NO
NUMBNESS	YES	NO
SEIZURES	YES	NO
WEAKNESS	YES	NO
IMBALANCE	YES	NO
DOUBLE VISION	YES	NO
BLURRY VISION	YES	NO
DECREASED VISION	YES	NO
WHICH EYE?	RT	LT
DECREASED HEARING	YES	NO
WHICH EAR?	RT	LT
RINGING IN EARS	YES	NO
WHICH EAR?	RT	LT

Please shade in area(s) of Pain



Please list any additional symptoms you may be having: _____

Do you have any medical conditions? (Cancer, Diabetes, Heart or Lung problems, etc….) YES NO

If yes, please list: _____

Have you had previous Brain Surgery? _____

What does your Doctor think is wrong? (circle) Migraines Multiple Sclerosis (MS) Stroke

Cancer Does not know Seizures

Other: _____

St. Joseph Hospital MRI
Body Questionnaire

PATIENT LABEL

Please circle appropriate exam(s)

NECK CHEST ABDOMEN MRCP PELVIS

Are you having any pain? YES NO

If yes, where? _____

Do you have any masses, lumps or swelling? YES NO

If yes, where? _____

Are you having any other symptoms? (weight loss, chronic cough, fatigue, etc…..) YES NO

If yes, please explain: _____

How long have you been having these symptoms? _____

Have you had any prior surgery to this area? YES NO

If yes, please explain: _____

Have you had any vascular surgery? (implanted devices, stents, grafts, filters, etc…...) YES NO

If yes, please explain: _____

Have you had any other procedures pertaining to this issue? (CT, ultrasound, labs, etc….) YES NO

If yes, please list: _____

Do you have any medical conditions we should be aware of? (Cancer, diabetes, etc…..) YES NO

If yes, please explain: _____

St. Joseph Hospital MRI
MRA Peripheral/ Run-Off Questionnaire

PATIENT LABEL

You are having an MRA examination of the blood vessels in your abdomen, pelvis, and legs. To help us serve you better, please answer the following questions.

Do you have leg pain when you walk? YES NO

If yes, which side? RIGHT LEFT

Where on your legs? UPPER MIDDLE LOWER

FRONT BACK

How far can you walk before it becomes painful? _____

Do you have leg pain at rest? YES NO

If yes, which side? RIGHT LEFT

Where on your legs? UPPER MIDDLE LOWER

FRONT BACK

Do you have any ulcers or sores on your ankles, legs, or feet that are slow to heal? YES NO

If yes, where? _____