Pembina High-Field MRI

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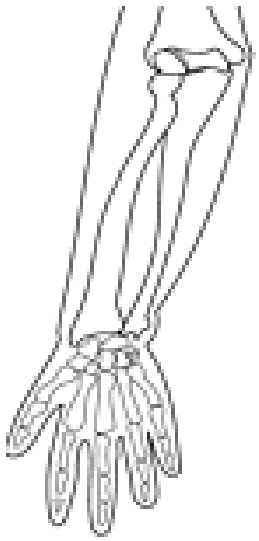


Patient History Sheet: Hand / Wrist / Forearm

Date of Exam: _____

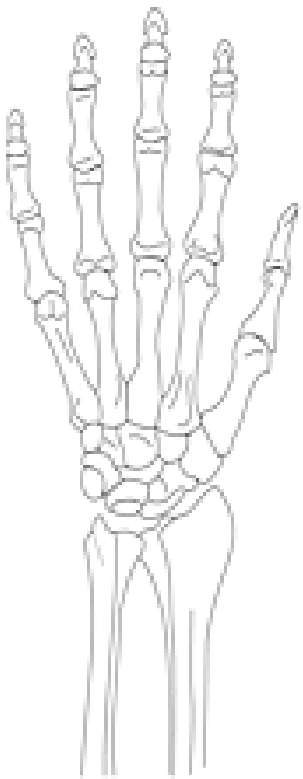
Name: _____ **Date of Birth:** _____

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.



❑ **Top** ❑ **Bottom** ❑ **Thumb side** ❑ **Little finger side**

Pain	❑ Yes	❑ No
Swelling	❑ Yes	❑ No
Stiffness	❑ Yes	❑ No
Bruising	❑ Yes	❑ No
Mass/lump	❑ Yes	❑ No
Fever/chills	❑ Yes	❑ No
Decreased strength	❑ Yes	❑ No
Numbness/burning sensation	❑ Yes	❑ No
Clicking/popping sensation	❑ Yes	❑ No
Pain with specific activity	❑ Yes	❑ No

If yes, please describe:
_____

Any history of cancer? ❑ Yes ❑ No Type: _____

Any plain hand, wrist or forearm 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 wrist/ hand/ forearm surgery on this extremity?
❑ Yes ❑ No **Date of surgery:** _____

What was done? _____
Where was it done? _____