Brain & Spine MRI Center

Patient Name: _____Date of Birth: _____
Date: _____

LOWER EXTREMITY JOINT EVALUATION

1. Describe what made you seek medical advice: _____
2. What does your doctor think is causing your problem? _____

   _____
3. Do you have any pain or discomfort? YES NO

   If you answered yes, please describe: _____

   _____
4. Does anything make it better? YES NO _____
5. Does anything make it worse? YES NO _____
6. Do you have any weakness? YES NO

   If you answered yes, please describe: _____
7. Have you ever dislocated the area being scanned today? YES NO
8. Have you ever broken any bones in the area being scanned today? YES NO
9. Have you had surgery or arthroscopy to the area being scanned today? YES NO

   If yes, please note when/where: _____
10. Do you have arthritis in any of your joints? YES NO
11. Do you have any other medical conditions? _____

    _____