

PAIN SHEET

Ankle/Foot Evaluation

| | | | | | |
|-------|-------|--------------|----------------|-------------|----------------|
| Name | | | Birth date | Referred by | Today's Date |
| _____ | | | ____/____/____ | Dr. _____ | ____/____/____ |
| Last | First | Middle Init. | mm/dd/yyyy | | mm/dd/yyyy |

– These questions apply only to the area being scanned today –

1. What was your chief complaint when you visited your doctor? _____

2. What do you think caused the problem? _____

3. What does your doctor think is causing your ankle/foot problem? _____

4. Describe your pain: _____

a) Does anything make it worse? _____

b) Does anything make it better? _____

5. Do you have any weakness? _____ Where? _____

6. Have you had surgery on the area being scanned today? _____

When? _____

What was done? _____

7. Have you ever broken any bones in your ankle/foot? _____

8. Do you have arthritis in any of your joints? _____

9. Do you have any other medical conditions? _____

10. Are you taking any medicines? _____ What kind? _____

11. Describe your general health: _____

Please complete BOTH sides.

Patient History and Safety Screening
MRI PATIENTS ONLY

Please answer all of the following questions:

YES NO

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | CARDIAC PACEMAKER |
| <input type="checkbox"/> | <input type="checkbox"/> | BRAIN VESSEL CLIPS |
| <input type="checkbox"/> | <input type="checkbox"/> | AORTIC CLIPS |
| <input type="checkbox"/> | <input type="checkbox"/> | ARTIFICIAL HEART VALVE |
| <input type="checkbox"/> | <input type="checkbox"/> | CORONARY, ARTERY OR HEART SURGERY, IF YES, WHEN? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | INSULIN PUMP |
| <input type="checkbox"/> | <input type="checkbox"/> | ELECTRODES |
| <input type="checkbox"/> | <input type="checkbox"/> | TENS UNITS OR PAIN STIMULATING UNIT |
| <input type="checkbox"/> | <input type="checkbox"/> | EAR SURGERY OR IMPLANTS |
| <input type="checkbox"/> | <input type="checkbox"/> | HEARING AIDS |
| <input type="checkbox"/> | <input type="checkbox"/> | METAL FRAGMENTS IN THE HEAD, EYE OR SKIN |
| <input type="checkbox"/> | <input type="checkbox"/> | HAVE YOU EVER WORKED WITH METAL OR AS A METAL WORKER? |
| <input type="checkbox"/> | <input type="checkbox"/> | METAL PLATES, PIN, SCREWS, NAILS OR CLIPS |
| <input type="checkbox"/> | <input type="checkbox"/> | ANY PREVIOUS SKULL SURGERY |

If yes, what was the surgery for: _____

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | IS THERE ANY CHANCE YOU ARE PREGNANT? (Not recommended for women in their first trimester of pregnancy) |
|--------------------------|--------------------------|--|

Signature of patient: _____

Signature of parent or guardian: _____

Date: _____

Please complete BOTH sides