

PAIN SHEET

Hip 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 hip 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 hip surgery? _____
When? _____
What was done? _____
7. Have you ever broken any bones in your hip? _____
8. Do you have arthritis in any of your joints? _____
9. Do you have any other medical conditions? _____

10. 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

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

If yes, what was the surgery for: _____

- 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