

# PAIN SHEET

# Wrist Evaluation

Name

Birth date

Referred by

Today's Date

\_\_\_\_\_

Last

\_\_\_\_\_

First

\_\_\_\_\_

Middle Init.

\_\_\_\_/\_\_\_\_/\_\_\_\_

mm/dd/yyyy

Dr. \_\_\_\_\_

\_\_\_\_/\_\_\_\_/\_\_\_\_

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 wrist 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 wrist surgery? \_\_\_\_\_  
When? \_\_\_\_\_  
What was done? \_\_\_\_\_
7. Have you ever broken any bones in your wrist? \_\_\_\_\_
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

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <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?<br>(Not recommended for women in their first trimester of pregnancy) |
|--------------------------|--------------------------|--|

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Signature of patient: \_\_\_\_\_

Signature of parent or guardian: \_\_\_\_\_

Date: \_\_\_\_\_

**Please complete BOTH sides**