MedStar Georgetown University Hospital

MedStar Georgetown Radiology
Musculoskeletal MRI Questionnaire

MRN _____

Last Name: _____ First Name: _____ Middle Initial: _____

Sex: ❑ Female ❑ Male Date of Birth: _____/_____/_____ Date of Service: _____ / _____ / _____

Name of Individual Completing this form: _____ Relationship to Patient: _____

Please describe the symptoms (or conditions) that have brought you here for an MRI. Please be as specific as possible.

How long have the symptoms been present? _____

Are your symptoms related to an injury? ❑ YES ❑ NO

If yes, what type of injury, and when did it occur?

What makes the symptoms worse? _____

What makes the symptoms better? _____

Have you ever had surgery or arthroscopy in the area being evaluated? ❑ YES ❑ NO

If yes, what surgery was performed and when was it done? Please be as specific as possible. If there have been multiple surgeries, please describe all relevant procedures.

Have you had other recent interventions in the area being scanned (e.g. steroid or anesthetic injection, aspiration, biopsy, etc.)? ❑ YES ❑ NO

If yes, please describe.

If this exam is being done for infection, do you have an ulcer or open wound/sore in the area being examined?
❑ YES ❑ NO

If yes, where exactly is it?

Do you have a history of any of the following? Please check ALL that apply.

❑ Psoriatic or Reactive Arthritis ❑ Ankylosing Spondylitis ❑ Gout ❑ Pseudogout

❑ Rheumatoid Arthritis ❑ Sarcoid ❑ Lupus (SLE) ❑ Steroid Use ❑ Sickle Cell ❑ TB ❑ Osteoporosis

❑ Scleroderma ❑ Calcific Tendonitis ❑ Diabetes Type 1 ☐ Type 2 ☐

❑ Cancer. What type(s)? _____ ❑ Radiation or Chemotherapy

❑ Endocrine, hormonal, or metabolic disease. What type(s)? _____

❑ Kidney failure. On dialysis? ❑ YES ❑ NO ❑ Inflammatory Bowel Disease

Other relevant medical information you wish to provide: