CEDARS-SINAI®

S. MARK TAPER FOUNDATION
IMAGING CENTER

X-RAY/CT/MRI MUSCULOSKELETAL QUESTIONNAIRE

PATIENT I.D.

1. When is your next appointment with your referring physician?
❑ Today ❑ Tomorrow ❑ No appt. ❑ Unknown ❑ Other: Next Appt. Date:_____

Attention: If patient's next appointment is today or the following day, please notify MSK Radiologist ASAP.

2. What is your main symptom/problem?
❑ Mass/Lump ❑ Limited Movement ❑ Pain ❑ Injury
Other: specify symptom(s):_____

3. Specify anatomical location of interest:
❑ Right ❑ Left
❑ Foot ❑ Ankle ❑ Elbow ❑ Hip ❑ Knee ❑ Shoulder ❑ Hand ❑ Wrist
Other specify:_____

4. How did this begin?_____
❑ Injury: Where did the injury occur?_____
How did the injury occur?_____
❑ Sports: Specify sport and explain injury in detail:_____
❑ Accident/Trauma: Explain the injury in detail:_____
❑ Other: Explain how symptom(s) began:_____
_____

5. When did the symptom(s) begin?_____
6. Has this injury/symptom been treated before? ❑ No ❑ Unknown
❑ Yes: With or Without Surgery? Circle One
Without surgery: Explain type of treatment:_____
With surgery:
Type of surgery?_____
When?_____
Facility?_____
Other related surgeries?_____

7. The patient has had prior imaging related to this injury/symptom:
❑ No ❑ Yes Date _____ Facility _____
❑ Radiographs (X-Ray) ❑ CT Scan ❑ MRI ❑ Arthrogram

8. Do you have any other medical problems?
❑ Arthritis ❑ Cancer ❑ Diabetes ❑ Gout
❑ Other: specify _____

9. Additional comments to report/mention to the radiologist?
❑ Yes: Additional Comments:_____ ❑ No

NAME OF PATIENT (please print)	SIGNATURE OF PATIENT	DATE	TIME
NAME OF TECHNOLOGIST (please print)	**SIGNATURE OF TECHNOLOGIST**	**DATE**	**TIME**

DISTRIBUTION: WHITE= Medical Records; Yellow= Patient