

Pembina High-Field MRI

AKA Direct Medical Imaging LLC

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Patient History Sheet: Hip / Thigh

Name: _____ Date of Exam: _____
Date of Birth: _____

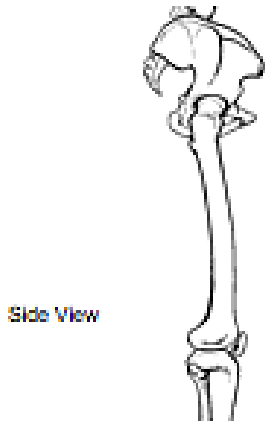
Which extremity? Right Left Is this from an injury? Yes No

Date of injury: _____
Describe injury: _____

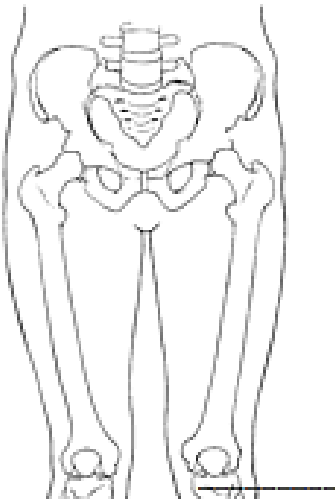
Symptoms:
How long have you had your symptoms? _____

Please check the area(s) affected below and shade affected area(s) to the left.

<input type="checkbox"/> Front	<input type="checkbox"/> Back	<input type="checkbox"/> Inside	<input type="checkbox"/> Outside
Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Weakness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Painful when lying on side	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Catching sensations	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Swelling	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Mass/lump	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Fever/chills	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Numbness/burning sensation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Any history of cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Type: _____



Side View



Any plain hip or thigh X-Rays taken?
 Yes No Date of X-Rays: _____

Site of X-Rays: _____
Findings: _____

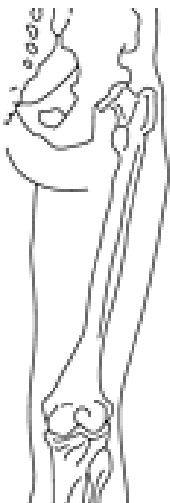
Any injections done?
 Yes No Date of injection: _____

Site of injection: _____
Any relief from the injection?
 Yes No

Any arthroscopic or open hip/thigh surgery on this extremity?
 Yes No Date of surgery: _____

What was done? _____
Where was it done? _____

Front View



mid 12/2007

Back View