



**Housatonic Valley Radiological Associates**

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*Community Based Imaging Excellence for Over 25 Years*

*Accredited by the American College of Radiology*

**KNEE MRI QUESTIONNAIRE**

Name \_\_\_\_\_ Acct # \_\_\_\_\_

Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_ Sex (M/F) \_\_\_\_\_ Age \_\_\_\_\_

Pertaining to your KNEE, have you ever had...

Previous MRI? \_\_\_\_\_ Where: \_\_\_\_\_ When: \_\_\_\_\_

Previous CT Scan? \_\_\_\_\_ Where: \_\_\_\_\_ When: \_\_\_\_\_

Previous Arthrogram? \_\_\_\_\_ Where: \_\_\_\_\_ When: \_\_\_\_\_

Background / Symptoms:

Did you have trauma? YES NO

If YES, please describe: \_\_\_\_\_

Have you ever had surgery on this knee? YES NO

If YES, which facility \_\_\_\_\_ Surgeon \_\_\_\_\_ Date \_\_\_\_\_

Do you have pain? YES NO

Inside of Knee \_\_\_\_\_ Outside of Knee \_\_\_\_\_ Behind Knee Cap \_\_\_\_\_ Behind Knee \_\_\_\_\_

Do you have:

Locking? YES NO      Clicking? YES NO

Swelling? YES NO      Limited Motion? YES NO

Duration of Symptoms: Days \_\_\_\_\_ Weeks \_\_\_\_\_ Months \_\_\_\_\_ Years \_\_\_\_\_

What does your doctor think is wrong? \_\_\_\_\_

Do you take medication? YES NO      What kind? \_\_\_\_\_