

MRI - Knee

Patient Name: _____ Date: _____

Affected **knee**?

Symptoms:	Yes	No
Pain in inside (medial) of knee	<input type="checkbox"/>	<input type="checkbox"/>
Pain in outside (lateral) of knee	<input type="checkbox"/>	<input type="checkbox"/>
Pain over kneecap	<input type="checkbox"/>	<input type="checkbox"/>
Pain behind knee	<input type="checkbox"/>	<input type="checkbox"/>
Limited motion of knee	<input type="checkbox"/>	<input type="checkbox"/>
Locking of knee	<input type="checkbox"/>	<input type="checkbox"/>
Lump or mass	<input type="checkbox"/>	<input type="checkbox"/>
If yes , where? _____		
Previous dislocation of kneecap	<input type="checkbox"/>	<input type="checkbox"/>
If yes , when? _____		

Do you feel your symptoms are related to a particular sport? **Yes / No**
 If **yes**, which one?

Have you had a recent knee injury? **Yes / No**
 If **yes**, when?

Have you had surgery on this knee? **Yes / No**
 If **yes**, what type?

Have you had a **previous MRI** of your knee? **Yes / No**
 If **yes**, when? _____ Where? _____

Do you have a return appointment with your physician? **Yes / No**
 If **yes**, when?