

**Eastern Radiologists, Inc. - Greenville MRI**  
**Lower Extremity Questionnaire**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ Birth date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Gender M F

Are you returning to you referring physician today? Y N Date of return: \_\_\_\_\_

Briefly describe your condition and how long you have had these symptoms. \_\_\_\_\_

\_\_\_\_\_

Did you have a specific injury? Y N Details/Dates: \_\_\_\_\_

\_\_\_\_\_

Does your joint ever slip out of place? Y N

Have you had any x-rays or other studies performed on your on affected area? If so, please indicate when, where, and results. \_\_\_\_\_

What prior treatments have you had on this area? (surgery, injections, physical therapy, etc) \_\_\_\_\_

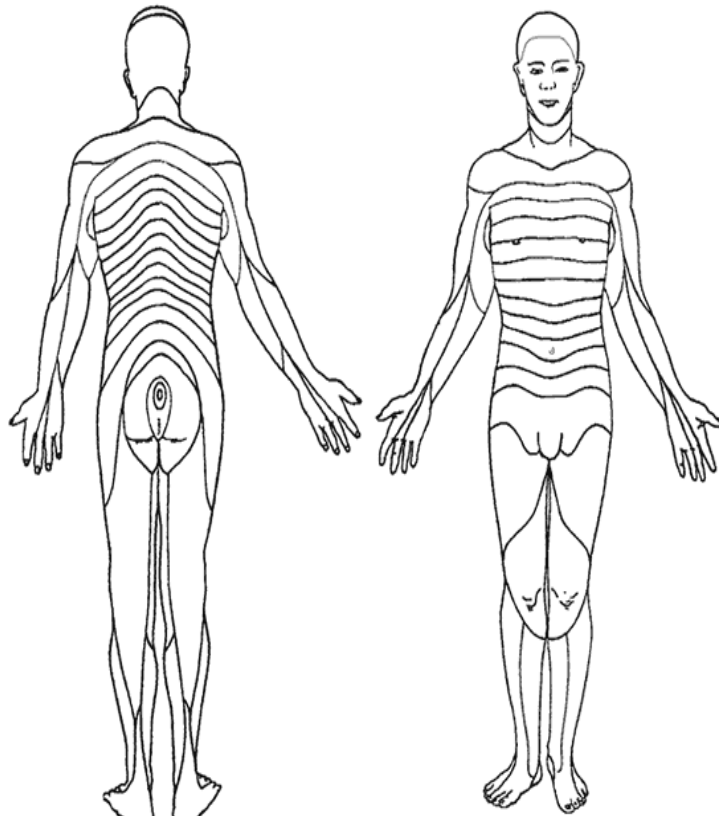
Please shade in areas of pain, weakness, and/or numbness.

**LEFT**

**RIGHT**

**RIGHT**

**LEFT**



Additional Comments:

\_\_\_\_\_