EASTERN RADIOLOGISTS
GREENVILLE MRI

2101 W Arlington Blvd, Suite 110, Greenville, NC 27834
Mon–Fri 7am–9pm • Sat / Sun 8am–8pm
252.752.5000 | easternrad.com

Patient Name _____ DOB ___ /___ /___ Date ___ /___ /___ MRN _____

QUESTIONNAIRE: UPPER EXTREMITY

Weight: _____ Height: _____ Gender: Male Female

Are you returning to your referring physician today? Yes No Date of return: _____

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

_____

Are you had a specific surgery? Yes No Details/Dates: _____

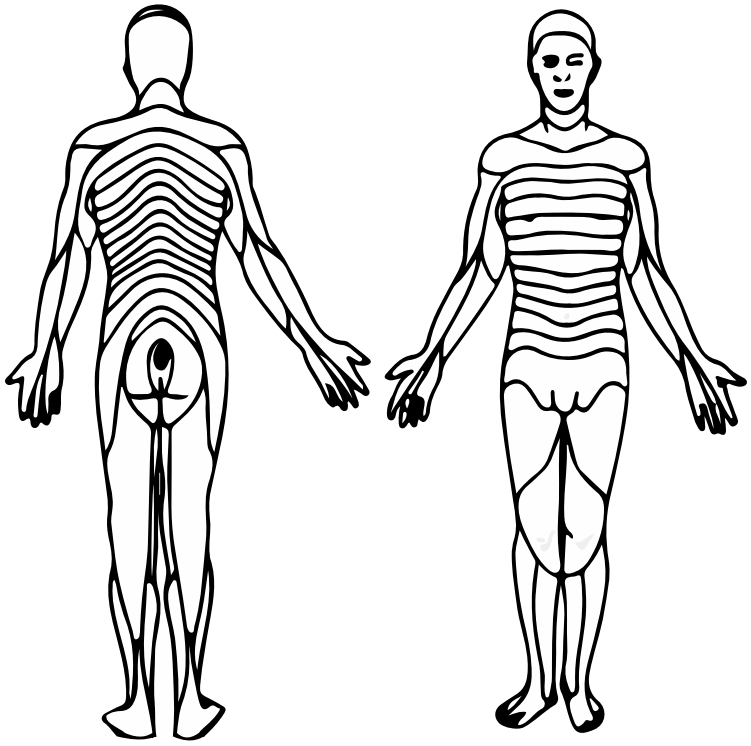
Does your joint ever slip out of place? Yes No

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 or numbness. Left Right Left Right



Additional comments: _____