

# PAIN SHEET

## Elbow Evaluation

Last Name

First

Middle Init. Age

Today's Date

### THESE QUESTIONS APPLY ONLY TO THE AREA BEING SCANNED TODAY

1. What was your chief complaint when you visited your doctor? \_\_\_\_\_  
\_\_\_\_\_

2. What do you think caused the problem? \_\_\_\_\_  
\_\_\_\_\_

3. What does your doctor think is causing your elbow Problem? \_\_\_\_\_  
\_\_\_\_\_

4. Describe your pain: \_\_\_\_\_

a. Does anything make it worse? \_\_\_\_\_

b. Does anything make it better? \_\_\_\_\_

5. Do you have any weakness? \_\_\_\_\_ Where? \_\_\_\_\_  
\_\_\_\_\_

6. Have you had surgery or arthroscopy to the area being scanned today? \_\_\_\_\_

When? \_\_\_\_\_

What was done? \_\_\_\_\_

7. Have you ever broken any bones in your Elbow? \_\_\_\_\_

8. Do you have arthritis in any of your joints? \_\_\_\_\_

9. Do you have any other medical conditions? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

10. Are you taking any medications? \_\_\_\_\_ What kind? \_\_\_\_\_

11. Describe your general health: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PLEASE COMPLETE BOTH SIDES

# Patient History and Safety Screening

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS:

Current Weight \_\_\_\_\_ (Needed for calibration of the MRI machine.)

YES NO

— — Cardiac Pacemaker

— — Brain Vessel Clips

— — Aortic Clips

— — Artificial Heart Valve

— — Coronary, Artery or Heart Surgery, if yes, when? \_\_\_\_\_

— — Insulin Pump

— — Electrodes

— — Tens Unit or Pain Stimulating Unit

— — Ear Surgery or Implants

— — Hearing Aids

— — Metal fragments in the head, eye or skin

— — Have you ever worked with metal or as a Metal Worker?

— — Metal Plates, Pins, Screws, Nails or Clips

— — Any previous Skull Surgery

— — If Yes, what was the surgery for: \_\_\_\_\_

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— — Is there any chance you are pregnant?

(Not recommended for women in their first trimester of pregnancy)

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Signature of Patient: \_\_\_\_\_

Signature of Parent or Guardian: \_\_\_\_\_

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

PLEASE COMPLETE BOTH SIDES