

# PAIN SHEET

## Hand/Finger 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 Hand/Finger 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 Hand/Finger? \_\_\_\_\_
8. Have you ever dislocated your Hand/Finger? \_\_\_\_\_
9. Do you have arthritis in any of your joints? \_\_\_\_\_
10. Do you have any other medical conditions? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
11. Are you taking any medications? \_\_\_\_\_ What kind? \_\_\_\_\_
12. 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**