

PATIENT QUESTIONNAIRE FORM RIGHT/LEFT KNEE EVALUATION

Patient Name _____

Tmed Number _____

What was your chief complaint when you visited your doctor?

What do you think caused your problem?

3. When did your symptoms begin?

4. Describe your pain and location?

5. Do you have any weakness with your knee?

6. Have you had any knee surgery or arthroscopy? If yes, when and where?

7. Do you hear any noise when you move the knee? Does it lock on you?

8. Have you ever fractured your knee before? If yes, when and where?

9. Do you have any history of arthritis to other parts of your body?

10. Have you had previous studies of your knee? C.T. M.R.I X-Ray

Other _____ Date of exam? _____

11. Where did you have it done? (Name of Diagnostic Center, Hospital, Dr's office)

Interviewed by _____ **Staff only** Scanned by _____ Filmed by _____

Date of next doctors appointment: _____

Technologist comment: _____

All original medical records are the property of UM - Applebaum Diagnostic Imaging Center and maintained by the Health Care Provider's Record Custodian. Copies of this form must be destroyed upon the completion of its temporary use. To receive a copy of your health information please contact your Health Care Provider's Record Custodian or the UM - Applebaum Diagnostic Imaging Center Release of Information department at (305) 243-5512.

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EVALUATION



Form
G0700008

Revised
06/01/05

NAME: _____

_____ UMMG # MRN

AGE: _____ DOB: _____ / _____ / _____

DATE OF SERVICE: _____