



**NEW YORK  
RADIOLOGY  
PARTNERS**

**East Manhattan Diagnostic Imaging**

P: 212.410.5100 F: 212.410.2500

**Union Square Diagnostic Imaging**

P: 212.473.2300 F: 212.473.4780

**Dove Open MRI**

P: 212.683.6200 F: 212.683.2992

**Kingsway Diagnostic**

P: 718.758.1500 F: 718.758.2400

**Columbus Circle Imaging**

P: 212.977.4100 F: 212.977.4271

## **MUSCULOSKELETAL IMAGING QUESTIONNAIRE**

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

What is the reason for this test? What are your symptoms and for how long have you experienced them?

Which side of the body does it affect? (Right or Left)

Has there been an injury to the area we are imaging today? If yes, please state the date and type of injury.

Have you had any surgeries performed on this area? If yes, please provide the date and type of surgery.

Have you had any prior X-rays, CT scan or MRI performed on this region? If yes, please state the results.

Do you have any medical illnesses? (E.g. Diabetes, Arthritis, Gout)