Lakemont Medical Center, 7499 Old Hwy. 441 South, Lakemont, GA 30552
Phone: 706-782-0770   Fax: 706-782-1091

MRI MUSCULOSKELETAL

Name___________________________________ Date __________________

Age__________ Weight __________

Type of exam____

Please give a brief description of your symptoms related to the area to be scanned:
____
____

History of fracture/dislocation? Yes____No____
If yes, give location, date of injury and treatment.
____
____

History of Cancer? Yes____No____
If yes, give location, treatment.
____
____

History of Arthritis? Yes____No____
If yes, give location and treatment.
____
____

Have you had any Cortisone injections into the affected joint? Yes____No____
If yes, which joint? ____

Have you had any surgery on the affected joint? Yes____No____
If yes, when? ____
Type of operation (if known)____

Prior scans (for the area being scanned today):

CT	Yes ___ No ___	When _________	Where __________________
MRI	Yes ___ No ___	When _________	Where __________________
X-ray	Yes ___ No ___	When _________	Where __________________
Nuc medicine	Yes ___ No ___	When _________	Where __________________
Arthrogram	Yes ___ No ___	When _________	Where __________________

Technologist__________________________