HTPN DALLAS DIAGNOSTIC ASSOCIATION

MAGNETIC RESONANCE IMAGING (MRI)
MUSCULOSKELETAL & TEMPOROMANDIBULAR JOINT (TMJ) QUESTIONNAIRE

Print Name:______________________________________________________ Date:________________

1) Reason you are having this MRI scan, include any recent or new complaints:____________________________________________________
How long have your symptoms been present?____________________________________________________________________________________

2) Check area to be imaged and please indicate:     Right □  Left □  Both □
□ Shoulder  □ Elbow  □ Wrist  □ TMJ
□ Hip  □ Knee  □ Ankle  □ Other:____________________________________________________

3) What are your major symptoms? (Limited movement, mass, infection, etc…)____________________________________________________
How long? _________________________

4) Is this problem related to an injury? □ Yes  □ No  □ Unknown
   If yes, Date of Injury: __________________
   Type of Injury: __________________________
   If this is a sports related injury, what sport? __________________________

5) Have you had any other types of previous surgery? ______  If yes, list the type of surgery and date:
____________________________________________________________________________________

6) Do you have a history of cancer? ______ If yes, what type? __________________________________________
   Did the treatment include:
   Radiation Therapy? □ Yes  □ No
   Chemotherapy? □ Yes  □ No
   If yes to radiation therapy, what part of your body? ________________  If yes, when? ________________

7) Have you had any previous imaging studies of this area? □ Yes  □ No
   * If yes, please indicate:
   **Type of Study:**
   Radiographs (X-rays)  ______  Date  ______  Facility
   Angiogram  ______  Date  ______  Facility
   Computed Tomography (CT)  ______  Date  ______  Facility
   Bone Scan (Nuclear Medicine)  ______  Date  ______  Facility
   MRI  ______  Date  ______  Facility
   Other  ______  Date  ______  Facility

8) TMJ specific questions: Have you experienced any of the following symptoms?

   a. clicking □  □  □  □
   b. popping □  □  □  □
   c. grinding teeth □  □  □  □
   d. pain □  □  □  □

9) Have you had surgery on your TMJ(s) or jaw? ______ If yes, approximate date of surgery:____________________

10) Have you had any orthodontic (braces) work? ______ If yes, when? __________________________

MRI Technologists Notes:
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________