

PAIN SHEET

Soft Tissue Evaluation

Name			Birth date	Referred by	Today's Date
_____			____/____/____	Dr. _____	____/____/____
Last	First	Middle Init.	mm/dd/yyyy		mm/dd/yyyy

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 problem? _____

4. If you have any pain, please describe it: _____

a) Does anything make it worse? _____

b) Does anything make it better? _____

5. Do you have a mass or lump you can feel? _____ If so, please indicate its location on the picture below.

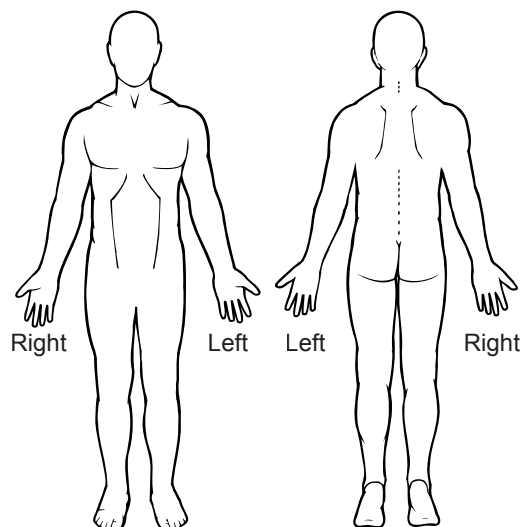
6. Have you had a biopsy or surgery? _____ When? _____

Do you know the results of the biopsy? _____

7. Do you have any other medical conditions? _____

8. Describe your general health: _____

Please indicate the area of interest, the location of any mass, or any area that hurts...



Please complete BOTH sides.

Patient History and Safety Screening
MRI PATIENTS ONLY

Please answer all of the following questions:

YES NO

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | CARDIAC PACEMAKER |
| <input type="checkbox"/> | <input type="checkbox"/> | BRAIN VESSEL CLIPS |
| <input type="checkbox"/> | <input type="checkbox"/> | AORTIC CLIPS |
| <input type="checkbox"/> | <input type="checkbox"/> | ARTIFICIAL HEART VALVE |
| <input type="checkbox"/> | <input type="checkbox"/> | CORONARY, ARTERY OR HEART SURGERY, IF YES, WHEN? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | INSULIN PUMP |
| <input type="checkbox"/> | <input type="checkbox"/> | ELECTRODES |
| <input type="checkbox"/> | <input type="checkbox"/> | TENS UNITS OR PAIN STIMULATING UNIT |
| <input type="checkbox"/> | <input type="checkbox"/> | EAR SURGERY OR IMPLANTS |
| <input type="checkbox"/> | <input type="checkbox"/> | HEARING AIDS |
| <input type="checkbox"/> | <input type="checkbox"/> | METAL FRAGMENTS IN THE HEAD, EYE OR SKIN |
| <input type="checkbox"/> | <input type="checkbox"/> | HAVE YOU EVER WORKED WITH METAL OR AS A METAL WORKER? |
| <input type="checkbox"/> | <input type="checkbox"/> | METAL PLATES, PIN, SCREWS, NAILS OR CLIPS |
| <input type="checkbox"/> | <input type="checkbox"/> | ANY PREVIOUS SKULL SURGERY |

If yes, what was the surgery for: _____

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | IS THERE ANY CHANCE YOU ARE PREGNANT?
(Not recommended for women in their first trimester of pregnancy) |
|--------------------------|--------------------------|--|

Signature of patient: _____

Signature of parent or guardian: _____

Date: _____

Please complete BOTH sides