

# PAIN SHEET

**\*\*Completed by all Imaging patients except CT only procedures\*\***

Last Name:	First Name:	Middle Init:	Date of Birth:
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## THESE QUESTIONS APPLY ONLY TO THE AREA BEING SCANNED TODAY

1. What was your chief complaint when you visited your doctor? \_\_\_\_\_  
\_\_\_\_\_
2. What do you think caused the problem? \_\_\_\_\_
  - a. How long have you had this problem? \_\_\_\_\_
3. What does your doctor think is causing your problem? \_\_\_\_\_
4. Describe your pain and location, please be specific:  
 Dull    Sharp    Aching    Other: \_\_\_\_\_  
 Front    Back    Inside    Outside    Other: \_\_\_\_\_  
 Right    Left    Shooting    Down leg?    Down Arm? \_\_\_\_\_
  - a. Does anything make it better? \_\_\_\_\_
  - b. Does anything make it worse? \_\_\_\_\_
5. Do you have any weakness? \_\_\_\_\_ Where? \_\_\_\_\_
6. Do you have any numbness? \_\_\_\_\_ Where? \_\_\_\_\_
7. Have you had surgery to the area being scanned today?    Yes    No
  - a. When? \_\_\_\_\_
  - b. What was done? \_\_\_\_\_
8. Have you ever broken any of your bones? \_\_\_\_\_
  - a. Do you have arthritis in any of your joints? \_\_\_\_\_
9. Do you have any other medical conditions? \_\_\_\_\_
  - a. History of cancer? \_\_\_\_\_
10. Describe your general health: \_\_\_\_\_
  - a. Are you taking any medications? \_\_\_\_\_

