

Trinitas Diagnostic Imaging

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Extremity Questionnaire

If you're coming to our center for this test, print this page, fill out the form and bring it in with you on the day of your appointment.

FIRST NAME

LAST NAME

AGE

WEIGHT

DATE

WHAT WAS YOUR CHIEF COMPLAINT WHEN YOU VISITED YOUR DOCTOR?

WHAT AREA IS AFFECTED?

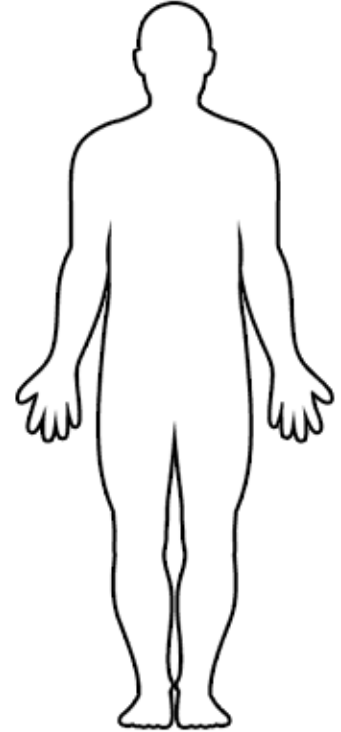
LEFT RIGHT

ANY SWELLING OR MASS?

WHAT DO YOU THINK CAUSED THE PROBLEM?

ANY OTHER MEDICAL CONDITIONS? YES NO

IF YES, PLEASE EXPLAIN:



Please circle the portion of your body that is in pain.

DESCRIBE YOUR GENERAL HEALTH: