



PELVIS / HIP QUESTIONNAIRE

RADIOLOGY

NAME: _____

DIAGNOSIS (What complaints or symptoms caused you to seek medical help?)

PLEASE CHECK EACH BOX THAT APPLIES TO YOU (AND ANSWER QUESTIONS):

How long have you had these symptoms? _____

Did they develop suddenly or gradually? Suddenly Gradually

Do you have hip pain? Yes No

 If yes, Right Left

Did you have an injury? Yes No

 If yes, date of injury: _____

What movement makes the pain worse?: _____

PRIOR STUDIES AND INTERVENTION:

Prior MRI (when?) _____ (where?) _____

X-Ray (when?) _____ (where?) _____

Are you taking or have you taken anticoagulant medication? Yes No

Are you taking or have you taken steroid medication? Yes No

What other medications are you currently taking? _____
