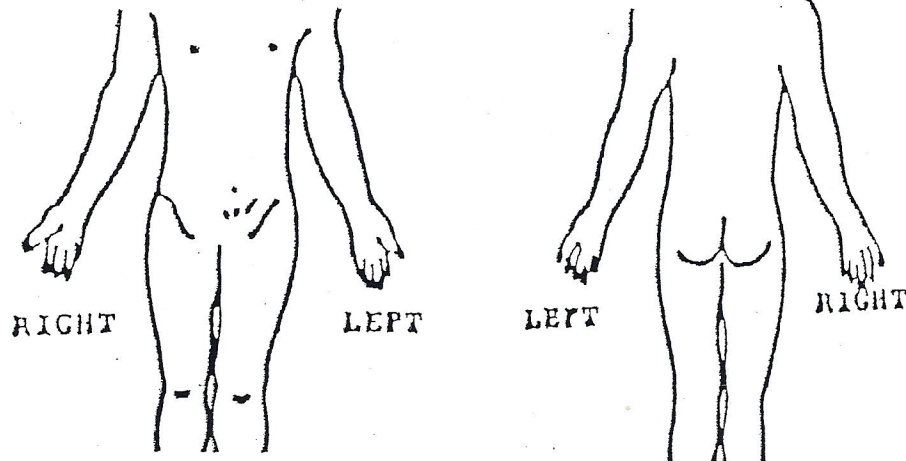


Patient # _____

Date _____

Thigh



Please circle on the above drawing where you are having pain or symptoms.

Describe the sensations or symptoms you are experiencing (pain, aching, tingling, burning, numbness, etc.)

Is this a result of an injury? YES ___ NO ___ If YES, give the date? _____ (month-day-year)

If YES, explain how and where your injury occurred: _____

Is this work related? YES ___ NO ___

If this was not an injury, how long have you been experiencing your symptoms? _____

Do you feel a lump in the area of concern? YES or NO (circle) If YES, please describe how it feels to you? (hard, soft, does it move around, is it close to the surface or does it feel deep?) _____

Is there discoloration of the area? YES ___ NO ___ If YES, describe _____

Have you ever had surgery on this thigh before? YES ___ NO ___ If YES, when, where, and what has the surgery done for you? _____

Have you ever had x-rays, a CT scan, or MRI scan for *this* problem? YES ___ NO ___ If YES, when and where, and what did they show? _____

Do you have a history of cancer? YES ___ NO ___ If YES, what type? _____
Are you currently being treated? _____

Please give us your HEIGHT _____ WEIGHT _____