



Community Based Imaging Excellence for Over 30 Years

Accredited by the American College of Radiology

**SHOULDER MRI QUESTIONNAIRE**

Name \_\_\_\_\_ Acct # \_\_\_\_\_

Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_ Sex (M/F) \_\_\_\_\_ Age \_\_\_\_\_

Pertaining to your SHOULDER, have you ever had...

Previous MRI? \_\_\_\_\_ Where: \_\_\_\_\_ When: \_\_\_\_\_

Previous CT Scan? \_\_\_\_\_ Where: \_\_\_\_\_ When: \_\_\_\_\_

Previous Arthrogram? \_\_\_\_\_ Where: \_\_\_\_\_ When: \_\_\_\_\_

Background / Symptoms:

Did you have trauma? YES NO

If YES, please describe: \_\_\_\_\_

Have you ever dislocated your shoulder? YES NO

If YES, please describe: \_\_\_\_\_

Have you ever had surgery on this shoulder? YES NO

If YES, which facility \_\_\_\_\_ By Whom \_\_\_\_\_ When \_\_\_\_\_

Do you have pain? YES NO

Are you having Numbness / Tingling in your arm? YES NO

Can you lift your arm? YES NO

Duration of Symptoms: Days \_\_\_\_\_ Weeks \_\_\_\_\_ Months \_\_\_\_\_ Years \_\_\_\_\_

What does your doctor think is wrong? \_\_\_\_\_

Do you take medication? YES NO What kind? \_\_\_\_\_