

MRI - Shoulder

Patient Name: _____ Date: _____

Affected shoulder? Right Left Both

Symptoms: **Yes** **No**

Pain in **front** of Shoulder

Pain in **back** of Shoulder

Pain on **top** of Shoulder

Pain with **raising** arm

Limited motion with raising arm

Locking of shoulder joint

Lump or mass

 If **yes**, where? _____

Previous **dislocation** of shoulder

 If **yes**, when? _____

Recent **injection** of shoulder

 If **yes**, when? _____

Do you feel your symptoms are related to a particular sport? **Yes / No**
If **yes**, which one?

Have you had a recent shoulder injury? **Yes / No**
If **yes**, when?

Have you had surgery on this shoulder? **Yes / No**
If **yes**, what type?

Have you had a **previous MRI** of your shoulder? **Yes / No**
If **yes**, when? Where?

Do you have a return appointment with your physician? **Yes / No**
If **yes**, when?