SHOULDER/ARM
MRI QUESTIONNAIRE

PATIENT WEIGHT_____ PATIENT HEIGHT_____

INJURY

Work-related Injury _____ Yes _____ No

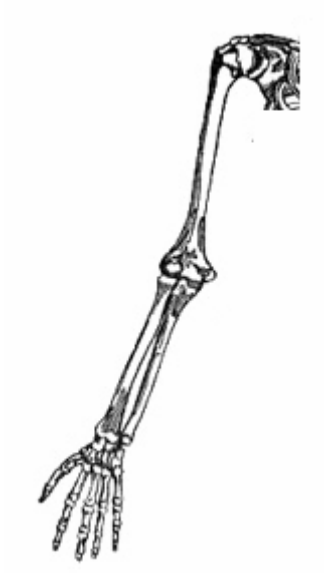
Motor Vehicle Accident _____ Yes _____ No

Sports Injury _____ Yes _____ No

Date of Injury_____

Describe Injury_____

Please indicate below where pain is located.



SYMPTOMS

_____ Pain _____Front of Shoulder _____Front of Arm

_____Back of Shoulder _____Back of Arm

_____Top of Shoulder _____Inside of Arm

_____Outside of Shoulder _____Outside of Arm

_____ Painful clicking sensation_____

_____ Pain with overhead activities_____

_____ Decreased strength_____

_____ Decreased range of motion_____

_____ Numbing/burning sensation_____

_____ Mass_____

_____ Cortisone/pain injections_____

How long have you had the above symptoms?_____

_____ History of medical disease (Parkinson's Disease, Arthritis, etc.)

Please describe_____

_____ History of cancer (please indicate primary cancer)

Please describe_____

PREVIOUS STUDIES PERTAINING TO CURRENT PROBLEM

X-Rays Yes No Where_____ Date_____

CT Scan Yes No Where_____ Date_____

MRI Scan Yes No Where_____ Date_____

Arthrogram Yes No Where_____ Date_____

Surgery/Arthroscopy

Yes No Where_____ Date_____

What was done? (please specify)_____

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Technologist Use: **Technologist _____** **Date _____**

Contrast: _____cc of _____ (type) injected into _____ (area).

Notes/Complications

_____

_____

_____

_____

_____