MRI Patient Clinical History Shoulder

Name:_____ Date of Birth:____/____/____

Describe the symptoms that you are having in this area (pain, numbness, tingling, weakness, etc.):_____

_____

_____

How long have you had these symptoms, and how often do they occur?_____

_____

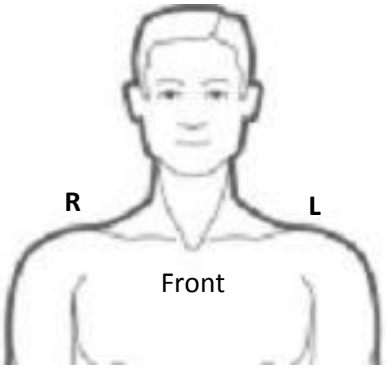
Are these symptoms related to a prior injury or surgery? If yes, then please describe:_____

_____

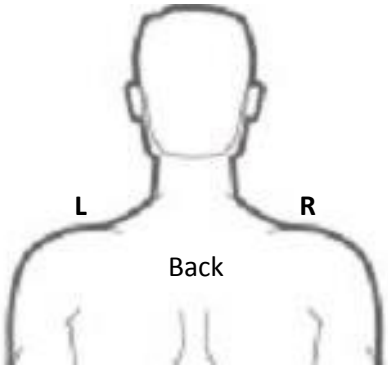
Has this area been imaged before?_____

Have you ever had surgery or other procedure in this area?_____

Please use the diagram and space below to detail your symptoms



Front



Back


Right


Left