



Advanced Imaging Newport Coast

PATIENT QUESTIONNAIRE

MRI SHOULDER

Please complete the following questions as best as you can

NAME : _____ DATE : _____

Do you have :

Yes **No**

1. Pain

Dull Ache _____ **Sharp Pain** _____ **Grinding** _____

2. Have you had surgery on this area ?

What was done ? _____

When ? _____

3. How long have you had this problem ? _____

4. How did the problem occur ?

Accident **Lifting** **Fall**

Surgery **Illness** **Other** _____

5. Do you have limited range of motion ?

6. Do you have weakness or instability ?