I-MED Radiology Network
Comprehensive care. Uncompromising quality.

Patient History Shoulder

Name: _____

Please describe your shoulder pain and how long you have had it for: _____

_____

_____

Please describe any movements that cause you pain: _____

_____

_____

How long have you had this pain for? _____

Have you had a specific injury to your shoulder? ◯ YES ◯ NO

If yes, when and describe the injury: _____

_____

Have you ever disclocated your shoulder? ◯ YES ◯ NO

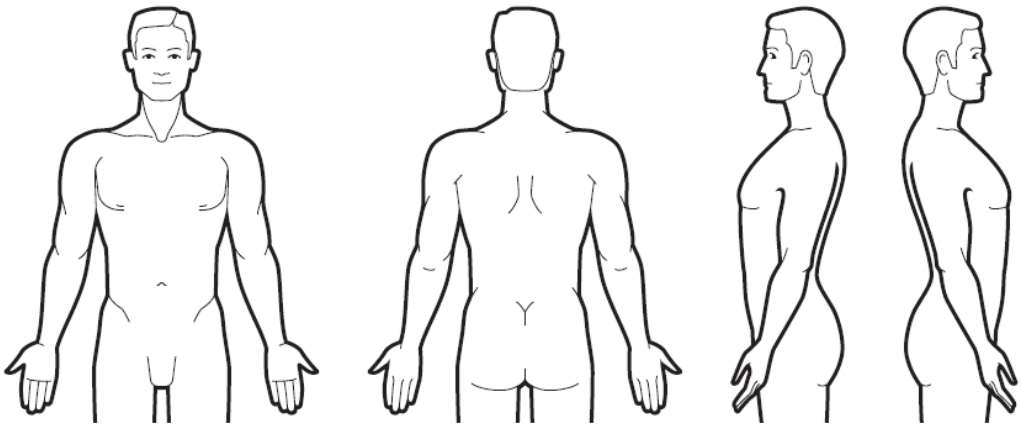
If yes, how many times, and the date of the most recent dislocation: _____

Have you had any of the following to your shoulder?

Surgery? ◯ YES ◯ NO

Arthroscopy (a scope) ◯ YES ◯ NO

Please indicate on the diagram any areas of discomfort or concern:



Have you had any of the following tests for this problem?

			If yes, when, where and results
X-rays	◯ NO	◯ YES	_____
CT (CAT) scan	◯ NO	◯ YES	_____
MRI scan	◯ NO	◯ YES	_____
Nuclear medicine scan	◯ NO	◯ YES	_____
Ultrasound	◯ NO	◯ YES	_____
Biopsy	◯ NO	◯ YES	_____
Other	◯ NO	◯ YES	_____