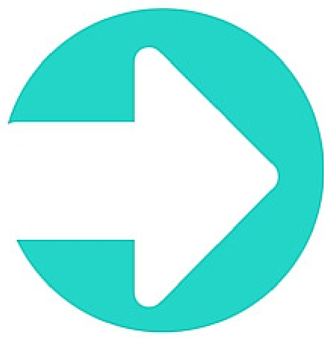


Pembina High-Field MRI

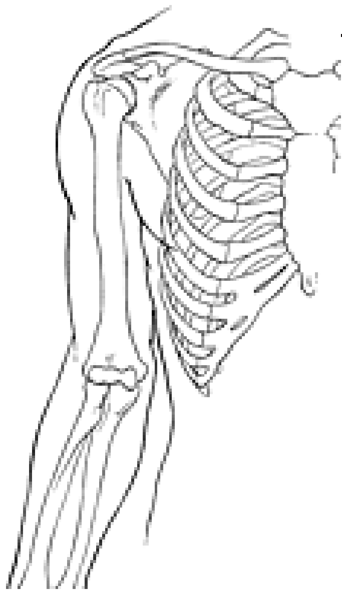
AKA Direct Medical Imaging LLC

P. 701-335-7742 F. 612-435-9211 E. info@pembinamri.com

Patient History Sheet: Shoulder / Arm / Elbow

Date of Exam: __________

Name: ____________________________________ **Date of Birth:** __



Which extremity? ❑ Right ❑ Left **Is this from an injury?** ❑ Yes ❑ No

Date of injury: ____

Describe injury: ____

____

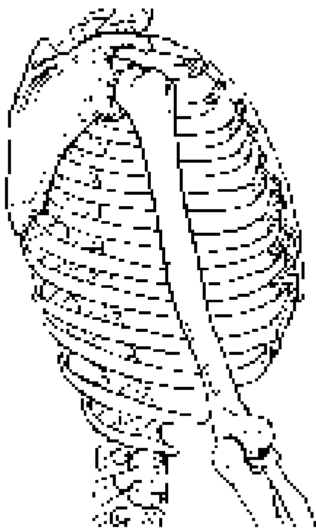
Symptoms:

How long have you had your symptoms? ________________________________

Please check the area(s) affected below and shade affected area(s) to the left.

❑ **Front** ❑ **Back** ❑ **Inside** ❑ **Outside**

Dislocation	❑ Yes	❑ No
Pain	❑ Yes	❑ No
Decreased strength	❑ Yes	❑ No
Decreased range of motion	❑ Yes	❑ No
Mass/lump	❑ Yes	❑ No
Fever/chills	❑ Yes	❑ No
Numbness/burning sensation	❑ Yes	❑ No
Any history of cancer	❑ Yes	❑ No Type: __________



Any plain shoulder, arm or elbow X-Rays taken?

❑ Yes ❑ No **Date of X-Rays:**__________

Site of X-Rays:____

Findings: ____

Any injections done?

❑ Yes ❑ No **Date of injection:** ________

Site of injection: ____

Any relief from the injection?

❑ Yes ❑ No

Any arthroscopic or open shoulder/arm/elbow surgery on this extremity?

❑ Yes ❑ No **Date of surgery:** __________

What was done? ____

Where was it done? ____