tollgateradiology.com 401.738.3100

SHOULDER CLINICAL QUESTIONNAIRE

WHICH SHOULDER? ☐ RIGHT ☐ LEFT

NAME: _____ DATE: _____

1. Why has your doctor sent you for this test? Did he/she give you a specific diagnosis?

   _____

   _____

2. Please describe what specific complaints/symptoms have been most bothersome to you?

   _____

   _____

3. How long have you had these complaints/symptoms? _____

4. Did these complaints/symptoms come on suddenly or gradually? _____

5. Are these symptoms the: ☐ same ☐ better ☐ worse

6. Please check if you have any of the following:

   ☐ Neck pain on the same side
   ☐ Difficulty raising your arm
   ☐ Numbness, tingling, weakness, or pain radiating down the same arm

7. Have you ever had a prior shoulder injury (including dislocation) ☐ yes ☐ no

   If yes, please describe: _____

8. Have you ever had surgery on this shoulder ☐ yes ☐ no

   ☐ Arthroscopic When and Where: _____
   ☐ Open Surgery When and Where: _____
   ☐ Shoulder Replacement When and Where: _____

9. Have you ever had an Arthrogram on this shoulder? ☐ yes ☐ no

   If yes, when and where? _____