ABDOMEN/BODY
MRI QUESTIONNAIRE

PATIENT WEIGHT_____ **PATIENT HEIGHT**_____

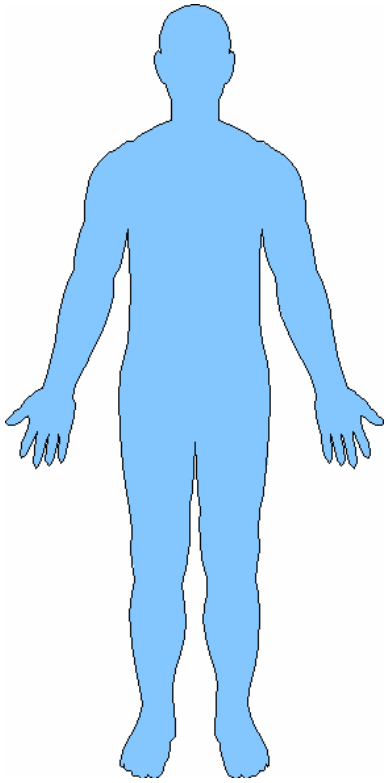
INJURY

_____ Yes _____ No Date of Injury_____

Describe Injury_____

Describe Symptoms_____

Please indicate below where pain is located.



SYMPTOMS	**Yes**	**No**
Stomach Pain?	____	____
Heart Disease?	____	____
Liver Disease?	____	____
Bladder or bowel problems?	____	____
Diabetes?	____	____
Kidney/gall stones?	____	____

_____ History of cancer (please indicate primary cancer)

Please describe_____

SURGICAL HISTORY

Chole (gallbladder) removed?	Yes	No	Date_____
Appendecotmy (appendix)?	Yes	No	Date_____
Colon resection?	Yes	No	Date_____
Hysterectomy?	Yes	No	Date_____
Lung surgery?	Yes	No	Date_____
Nephrectomy (kidney)?	Yes	No	Date_____
Mastectomy (breast)?	Yes	No	Date_____
Prostate surgery?	Yes	No	Date_____
Liver surgery?	Yes	No	Date_____

What was done? (please specify)_____

PREVIOUS STUDIES PERTAINING TO CURRENT PROBLEM

X-Rays	Yes	No	Where_____	Date_____
CT Scan	Yes	No	Where_____	Date_____
MRI Scan	Yes	No	Where_____	Date_____
Myelogram	Yes	No	Where_____	Date_____

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Technologist Use: **Technologist** _____ **Date** _____

Contrast: _____cc of _____ (type) injected into _____ (area).

Notes/Complications _____

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_____

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