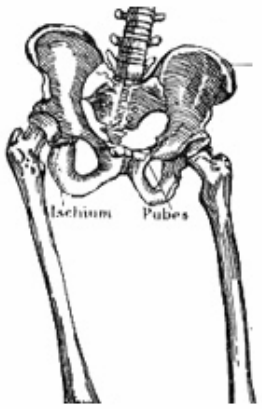
PELVIS
MRI QUESTIONNAIRE

PATIENT WEIGHT_____ **PATIENT HEIGHT_____**

INJURY
Any specific injury or trauma? _____ Yes _____ No
Date of Injury_____
Describe Injury_____

SYMPTOMS
_____ Abdominal pain? _____
_____ Pain with urination? _____
_____ Pain in flank area? _____
_____ Lower back pain? _____
_____ History of kidney/gall stones? _____

Please indicate below where pain is located.



Male:
_____ Problems with ejaculation? _____
_____ Testosterone levels increase/decrease?_____
_____ Blood in stools? Change in bowel habits?_____
_____ Bladder incontinence? _____
_____ Prostate cancer/surgery?_____
_____ Kidney stones? _____

Female
Yes No Hormonal imbalance?_____
Yes No Menstrual irregularities?_____
Yes No Endometriosis? _____
Yes No Bowel changes? Blood in stool?_____
Yes No Bladder incontinence? _____
Yes No Surgery; Hysterectomy (uterus), oophorectomy (ovaries)?_____
How long have you had the above symptoms?_____
_____ History of medical disease (Parkinson's Disease, Arthritis, etc.)
Please describe_____
_____ History of cancer (please indicate primary cancer)
Please describe_____

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_____
Surgery/Arthroscopy
Yes No Where_____ Date_____
What was done? (please specify)_____

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Technologist Use: **Technologist _____** **Date _____**
Contrast: _____cc of _____ (type) injected into _____ (area).
Notes/Complications
_____
_____
_____
_____
_____
_____
_____