



MRI/MRA CHEST/ABDOMEN/PELVIS QUESTIONNAIRE

PATIENT NAME _____

DATE _____ DATE OF BIRTH _____

What is your present complaint or problem? _____

How long ago did these symptoms first appear? _____

What were you doing when the symptoms started (was there a specific injury)? _____

Have you had surgery in the area we are scanning? ____ Yes ____ No

If yes, when and what did they do? _____

Do you currently have or in the past have you had:

Cancer? Yes () No () What type/year diagnosed? _____

Hereditary Disease? Yes () No () Specify: _____

Diabetes? Yes () No ()

Kidney Disease? Yes () No ()

Heart Disease? Yes () No ()

Immune Disease? Yes () No ()

Multiple Sclerosis? Yes () No ()

Other _____

Have you had any other previous studies for this problem?

MRI Yes() No() Date ___/___/___ Where? _____

CT Yes() No() Date ___/___/___ Where? _____

X-Ray Yes() No() Date ___/___/___ Where? _____

Ultrasound Yes() No() Date ___/___/___ Where? _____

PET Yes() No() Date ___/___/___ Where? _____

Bone Scan Yes() No() Date ___/___/___ Where? _____