

**HILLSBOROUGH RADIOLOGY ASSOCIATES, PA.
MRI QUESTIONNAIRE-PELVIS**

NAME: _____ D.O.B: ____/____/____
(Last) (First)

AGE: _____ SEX: M / F WEIGHT: _____ HEIGHT: ____ ft. ____ in.

REFERRING PHYSICIAN: _____

- What type of problem are you having? _____
- Was this a result of an injury? _____
- How long have you had this problem? _____
- Do you have a history of being diagnosed with cancer? Yes ___ No ___ Type _____
- Have you been treated with either radiation or chemotherapy? (If yes, circle) Date completed _____
- Have you ever had surgery on your pelvis? Yes ___ No ___ When: _____
- If yes, please explain what was done _____
- **Do you have, or have you ever had, any of the following?: (If yes, circle)**

PACEMAKER/DEFIBRILLATOR

METAL SLIVERS IN EYES

IUD

DIABETES or KIDNEY DISEASE

SHRAPNEL (bomb or bullet fragments)

HEARING AID

COCHLEAR IMPLANTS

BREAST TISSUE EXPANDER

BODY PIERCING

HEART VALVE REPLACEMENT

NEURO STIMULATOR

PENILE IMPLANT

TATOOS (over 20 years old)

PESSARY (bladder support)

ANEURYSM CLIPS

REMOVABLE DENTAL WORK/DENTURES

ENDOSCOPY CLIPS/INGESTED PILL CAMERA/PH BRAVO CAPSULE

MEDICATION PATCH (birth control/nicotine/Nitroglycerine)

ANY EXTERNAL/INTERNAL PUMPS (i.e., Insulin, chemotherapy)

Regarding the area being scanned today:

- | | Yes ___ No ___ | When | Where |
|---|----------------|-------|-------|
| • Have you had any x-rays taken recently? | Yes ___ No ___ | _____ | _____ |
| • Have you had any ultrasound exams recently? | Yes ___ No ___ | _____ | _____ |
| • Have you had a bone scan? | Yes ___ No ___ | _____ | _____ |
| • Have you had a CT or MRI? | Yes ___ No ___ | _____ | _____ |

For male patients having prostate study:

- Have you had a biopsy of your prostate? Yes ___ No ___ When _____
- What is your PSA level? _____

For female patients:

- What was the 1st day of your last menstrual period? _____
- **Are you pregnant, or is there a possibility that you might be pregnant? Yes ___ No ___**
- Do you have a history of allergies? Yes ___ No ___ If so, what kind? _____
- Do you have an allergy to latex? Yes ___ No ___

I acknowledge that all the information given is accurate and thereby consent to have Magnetic Resonance Imaging with or without an injection of contrast performed on me. I do not have a pacemaker. I have removed all hearing aids and dentures and any external pumps and monitoring devices.

 Signature of Patient or Legal Guardian Date: ____/____/____ Technologist's Initials: _____

Technologist to Complete the Section Below

MR # _____ **Designated Physician On-Site:** _____
Tech: _____ **Supervising Physician (if different):** _____
 Contrast Used : OPTIMARK / _____ mls Lot # _____