



MRI QUESTIONNAIRE-PELVIS

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

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

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)

- | | |
|----------------------------------|--------------------------------------------|
| PACE MAKER | METAL SLIVERS IN EYES |
| ANEURYSM CLIPS | SHRAPNEL (bomb or bullet fragments) |
| COCHLEAR IMPLANTS | HEARING AID |
| HEART VALVE REPLACEMENT | REMOVEABLE DENTAL WORK/DENTURES |
| NEURO STIMULATOR | TATOO'S (over 20 yrs old) |
| PESSARY (Bladder Support) | IUD |
| BODY PIERCING | PENILE IMPLANT |

Regarding the area being scanned today:

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

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 performed on me. I do not have a pacemaker. I have removed all hearing aids and dentures.

Patient's Signature: _____ Date: ___/___/___

Technologist to Complete Below this Line

Rad authorizing IV Contrast: _____ Tech: _____ Study Protooled By: _____
Contrast Used: _____/_____ cc's Lot#: _____ Study Checked By: _____