



MRI QUESTIONNAIRE-PELVIS

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

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

- **Regarding the area being scanned today:**
- Have you had any x-rays taken recently? Yes ___ No ___ When _____ Where _____
- 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 ___
- **Have you spoken with a physician regarding uterine artery embolization? Yes ___ No ___**
- **Are you considering embolization for uterine fibroids? 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.

_____ Date: ___/___/___ Technologist Initials: _____
 Patient's Signature Verified Checked Initials: _____

TECHNOLOGIST TO COMPLETE Below This Line

Rad authorizing IV Contrast: _____ Tech: _____ Study Protocolled by: _____

Contrast used: _____ Volume: _____ cc's Lot#: _____ Study Checked by: _____