MRI EVALUATION FOR ABDOMEN AND PELVIS

Patient: ____

The following questionnaire is essential to help determine the best possible method in which to do your particular exam.

1. Briefly describe what made you go to see your doctor? ______________________
____
____

2. Are you having any pain, pressure, tenderness, or discomfort? Please describe: ______
____
____
____
____

3. Circle any of the following symptoms that apply:

Nausea Vomiting Diarrhea Constipation Night Sweats

Fluid Retention Sudden Weight Loss Frequent Urination

Difficult/painful urination

4. Have you ever had any abdominal surgery? Y N

If yes, what kind? ____
____

5. Do you have any other medical conditions? ______________________
____
____

6. Do you have any allergies? ____
____

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