ABDOMINAL & PELVIC HISTORY

What are your major complaints of pain?____

How and when the pain start?____

Are you allergic to any medications? Please list.____

Have you had any recent weight loss? Yes___No___

When was the last time you ate?____

Do you have any medical conditions? (ex: diabetes, high blood pressure etc.)

____

Do you have any kidney problems? Yes___No___

Are you currently on dialysis? Yes___No___

Have you ever been diagnosed with cancer? Yes___No___

If so, What kind of cancer?______________________ When was diagnosis?____________________

Chemotherapy? Yes___No___ Radiation? Yes___No___

Have you had surgery in the area to be scanned? Yes___No___ When?________________

Please list any surgeries you have had in your lifetime:

____

Have you had the following studies? MRI______CT Scan _____ Ultrasound______ Pelvic Exam______

Where?__________________________ When?________________________

Results:____

Female Patients only:

Number of pregnancies_________ Number of births__________ LMP____________

Abnormal Bleeding Yes___No___ Vaginal discharge Yes___No___

Technologist Documentation

Justify frequency of MRI scan:_____________________________ Contrast Amount:__________

Technologist signature:___________________________________ Date:____________________