

HIGH FIELD OPEN MRI PATIENT QUESTIONNAIRE
MRI ABDOMEN/PELVIS

Name _____ Date _____

Do you have any history of cancer? If yes, please detail _____

Date of diagnosis _____

What complaints or symptoms led you to seek medical help? _____

How long have you had these symptoms? _____

Do you have abdominal pain? If so, please check:

___ UPPER LEFT QUADRANT

___ UPPER RIGHT QUADRANT

___ LOWER LEFT QUADRANT

___ LOWER RIGHT QUADRANT

Do you have or have you had:

Hematuria (blood in urine) ___ YES ___ NO

History of kidney or gall stones ___ YES ___ NO

Abdominal/pelvic surgery ___ YES ___ NO

If yes, for what?

Please note any other symptoms related to this exam and any results of previous studies

