

**MRI QUESTIONNAIRE-PELVIS**

NAME: \_\_\_\_\_ D.O.B: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Last) (First)

AGE: \_\_\_\_\_ 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)**

- |  |  |                       |
|--|--|-----------------------|
| <b>PACEMAKER/DEFIBRILLATOR</b>                                   | <b>METAL SLIVERS IN EYES</b>               | <b>IUD</b>            |
| <b>DIABETES or KIDNEY DISEASE</b>                                | <b>SHRAPNEL (bomb or bullet fragments)</b> | <b>HEARING AID</b>    |
| <b>COCHLEAR IMPLANTS</b>   | <b>BREAST TISSUE EXPANDER</b>              | <b>BODY PIERCING</b>  |
| <b>HEART VALVE REPLACEMENT</b>                                   | <b>NEURO STIMULATOR</b>                    | <b>PENILE IMPLANT</b> |
| <b>TATOOS (over 20 years old)</b>                                | <b>PESSARY (bladder support)</b>           | <b>ANEURYSM CLIPS</b> |
| <b>REMOVABLE DENTAL WORK/DENTURES</b>                            |  |                       |
| <b>ENDOSCOPY CLIPS/INGESTED PILL CAMERA/PH BRAVO CAPSULE</b>     |  |                       |
| <b>MEDICATION PATCH (birth control/nicotine/Nitroglycerine)</b>  |  |                       |
| <b>ANY EXTERNAL/INTERNAL PUMPS (i.e., Insulin, chemotherapy)</b> |  |                       |

**Regarding the area being scanned today:**

- |   | Yes ___ No ___ | When  | Where |
|---|----------------|-------|-------|
| • Have you had any x-rays taken recently?     | Yes ___ No ___ | _____ | _____ |
| • 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 1<sup>st</sup> 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 with or without an injection of contrast performed on me. I do not have a pacemaker. I have removed all hearing aids and dentures and any external pumps and monitoring devices.

Signature of Patient or Legal Guardian \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Technologist's Initials: \_\_\_\_\_

**Technologist to Complete the Section Below**

**MR #** \_\_\_\_\_ **Designated Physician On-Site:** \_\_\_\_\_  
**Tech:** \_\_\_\_\_ **Supervising Physician (if different):** \_\_\_\_\_  
 Contrast Used : OPTIMARK / \_\_\_\_\_ mls Lot # \_\_\_\_\_