Princeton Radiology
Excellence in Imaging

MRI QUESTIONNAIRE-**PELVIS**

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

AGE: _____ SEX: M / F WEIGHT: _____ HEIGHT: _____ft. _____in. MR#_____

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	**METAL SLIVERS IN EYES**
ANEURYSM CLIPS	**SHRAPNEL (bomb or bullet fragments)**
COCHLEAR IMPLANTS	**HEARING AID**
HEART VALVE REPLACEMENT	**REMOVABLE DENTAL WORK/DENTURES**
NEURO STIMULATOR	**TATTOOS (over 20 yrs old)**
PESSARY (Bladder Support)	**IUD**
BODY PIERCING	**PENILE IMPLANT**

Regarding the area being scanned today: 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 1st 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 performed on me. I do not have a pacemaker. I have removed all hearing aids & dentures.

_____ **Date:** _____/_____/_____
Patient's Signature

Technologist to Complete Below this Line

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

Contrast Used : _____ / _____ cc's Lot # _____ Study Checked by: _____

*This form was downloaded from www.princetonradiology.com.