iCare Diagnostic Imaging, LLC
2781 Freeway Blvd
Suite 160
Brooklyn Center, MN 55430

ABDOMEN/BODY MRI QUESTIONNAIRE

PATIENT WEIGHT__________**PATIENT HEIGHT**__________

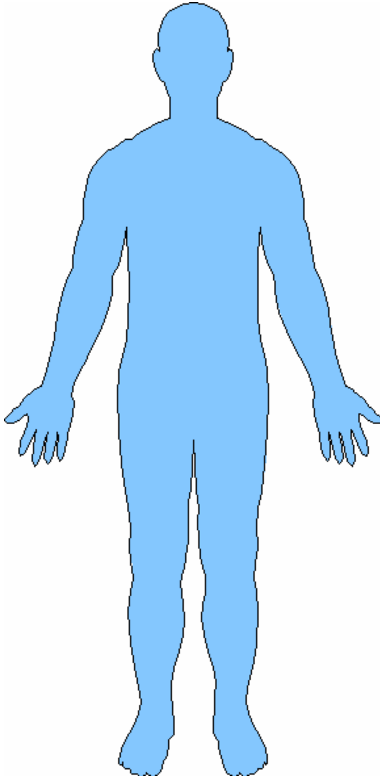
INJURY

_____ Yes_____ No Date of Injury____________________________

Describe Injury____

Describe Symptoms____

Please indicate below where pain is located.



SYMPTOMS	**Yes**	**No**
Stomach Pain?	____	____
Heart Disease?	____	____
Liver Disease?	____	____
Bladder or bowel problems?	____	____
Diabetes?	____	____
Kidney/gall stones?	____	____

_____ History of cancer (please indicate primary cancer)

Please describe____

SURGICAL HISTORY

Chole (gallbladder) removed?	Yes	No	Date____________________
Appendecotmy (appendix)?	Yes	No	Date____________________
Colon resection?	Yes	No	Date____________________
Hysterectomy?	Yes	No	Date____________________
Lung surgery?	Yes	No	Date____________________
Nephrectomy (kidney)?	Yes	No	Date____________________
Mastectomy (breast)?	Yes	No	Date____________________
Prostate surgery?	Yes	No	Date____________________
Liver surgery?	Yes	No	Date____________________

What was done? (please specify)____

PREVIOUS STUDIES PERTAINING TO CURRENT PROBLEM

X-Rays	Yes	No	Where________________	Date__________
CT Scan	Yes	No	Where________________	Date__________
MRI Scan	Yes	No	Where________________	Date__________
Myelogram	Yes	No	Where________________	Date__________

****

Technologist Use: **Technologist** ___________________________ **Date** ________________

Contrast: ____________cc of _____________________ (type) injected into ______________________ (area).

Notes/Complications ____

____

____