



**iCare Diagnostic Imaging, LLC**  
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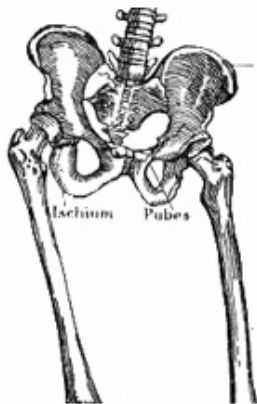
**PELVIS  
 MRI QUESTIONNAIRE**

**PATIENT WEIGHT** \_\_\_\_\_ **PATIENT HEIGHT** \_\_\_\_\_  
**INJURY**  
 Any specific injury or trauma? \_\_\_\_\_ Yes \_\_\_\_\_ No  
 Date of Injury \_\_\_\_\_  
 Describe Injury \_\_\_\_\_

**SYMPTOMS**

\_\_\_\_\_ Abdominal pain? \_\_\_\_\_  
 \_\_\_\_\_ Pain with urination? \_\_\_\_\_  
 \_\_\_\_\_ Pain in flank area? \_\_\_\_\_  
 \_\_\_\_\_ Lower back pain? \_\_\_\_\_  
 \_\_\_\_\_ History of kidney/gall stones? \_\_\_\_\_

Please indicate below  
 where pain is located.



**Male:**

\_\_\_\_\_ Problems with ejaculation? \_\_\_\_\_  
 \_\_\_\_\_ Testosterone levels increase/decrease? \_\_\_\_\_  
 \_\_\_\_\_ Blood in stools? Change in bowel habits? \_\_\_\_\_  
 \_\_\_\_\_ Bladder incontinence? \_\_\_\_\_  
 \_\_\_\_\_ Prostate cancer/surgery? \_\_\_\_\_  
 \_\_\_\_\_ Kidney stones? \_\_\_\_\_

**Female**

Yes No Hormonal imbalance? \_\_\_\_\_  
 Yes No Menstrual irregularities? \_\_\_\_\_  
 Yes No Endometriosis? \_\_\_\_\_  
 Yes No Bowel changes? Blood in stool? \_\_\_\_\_  
 Yes No Bladder incontinence? \_\_\_\_\_  
 Yes No Surgery; Hysterectomy (uterus), oophorectomy (ovaries)? \_\_\_\_\_  
 How long have you had the above symptoms? \_\_\_\_\_  
 \_\_\_\_\_ History of medical disease (Parkinson's Disease, Arthritis, etc.)  
 Please describe \_\_\_\_\_  
 \_\_\_\_\_ History of cancer (please indicate primary cancer)  
 Please de-  
 scribe \_\_\_\_\_

**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 \_\_\_\_\_  
 Surgery/Arthroscopy Yes No Where \_\_\_\_\_ Date \_\_\_\_\_  
 What was done? (please specify) \_\_\_\_\_

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**Technologist Use:** \_\_\_\_\_ **Technologist** \_\_\_\_\_ **Date** \_\_\_\_\_  
 Contrast: \_\_\_\_\_ cc of \_\_\_\_\_ (type) injected into \_\_\_\_\_ (area).

**Notes/Complications**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_