HTPN DALLAS DIAGNOSTIC ASSOCIATION

MAGNETIC RESONANCE IMAGING (MRI)
ABDOMEN QUESTIONNAIRE

Print Name:_____ **Date:**_____

1) Reason you are having this MRI scan, include any recent or new complaints:_____
_____

How long have your symptoms been present? _____

2) What are your major symptoms? (pain, mass, infection, etc…)
_____
_____

For how long? _____

3) Do you have a history of cancer? _____ If yes, what type? _____
Did the treatment include:
Radiation Therapy? □ Yes □ No
Chemotherapy? □ Yes □ No
If yes to radiation therapy, what part of your of your body?_____If yes, when?_____

4) Have you had any other types of previous surgery? _____ If yes, list the type of surgery and date:
_____ _____
_____ _____

5) Are you scheduled or will you be scheduled in the future for a transplantation of an organ?
If yes, what body part (or organ)? _____

6) Have you had any previous imaging studies of this area? ☐ Yes ☐ No
* If yes, please indicate:

Type of Study:	**Date**	**Facility**
Radiographs (X-rays)	_____	_____
Angiogram	_____	_____
Computed Tomography (CT)	_____	_____
Bone Scan (Nuclear Medicine)	_____	_____
MRI	_____	_____
Other	_____	_____

MRI Technologists Notes:
_____
_____
_____