NORTH DOVER RADIOLOGY

CHEST /ABDOMEN/PELVIS MRI QUESTIONNAIRE

DATE:_____

NAME _____ DOB _____ AGE _____

WHAT COMPLAINTS OR SYMPTOMS LED YOU TO SEE YOUR DOCTOR?

_____

_____

HAVE YOU HAD SURGERY FOR ANY OF THE FOLLOWING ?

CHEST/LUNG/HEART	YES	NO	WHAT TYPE?_____
LIVER	YES	NO	WHAT TYPE?_____
SPLEEN	YES	NO	WHAT TYPE?_____
KIDNEY	YES	NO	WHAT TYPE?_____
COLON/BOWEL	YES	NO	WHAT TYPE?_____
ULCER	YES	NO	WHAT TYPE?_____
APPENDIX	YES	NO	WHAT TYPE?_____
GALLBLADDER	YES	NO	WHAT TYPE?_____
HYSTERECTOMY	YES	NO	WHAT TYPE?_____
OVARIES	YES	NO	WHAT TYPE?_____
PROSTATE	YES	NO	WHAT TYPE?_____
COLOSTOMY	YES	NO	WHAT TYPE?_____
HERNIA	YES	NO	WHAT TYPE?_____
OTHER	**YES**	**NO**	**WHAT TYPE?_____**

PLEASE LIST ANY OTHER MEDICAL PROBLEMS THAT YOU HAVE, OR HAVE HAD IN THE PAST.

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_____

PLEASE LIST ANY AND ALL MEDICATIONS YOU ARE CURRENTY TAKING.

_____

_____

PATIENT SIGNATURE _____