

MRI PATIENT QUESTIONNAIRE

GENERAL

NAME: _____ DATE: _____

WHAT PROBLEMS ARE YOU HAVING THAT LED YOU TO HAVE THIS SCAN?

HAD YOU HAD ANY SURGERY ON THE FOLLOWING?

CHEST? _____ WHAT KIND? _____ WHEN? _____

ABDOMINAL? _____ WHAT KIND? _____ WHEN? _____

PELVIS? _____ WHAT KIND? _____ WHEN? _____

OTHER? _____ WHAT KIND? _____ WHEN? _____

DO YOU HAVE ANY OTHER MEDICAL PROBLEMS?

ANY HISTORY OF CANCER, RADIATION, OR CHEMOTHERAPY?

WHAT TYPE? _____ WHEN? _____