ADVANTAGE+ MRI
Excellence in High Field Imaging

MRI Patient Clinical History
Abdomen / Pelvis

Name: _____ Date: _____

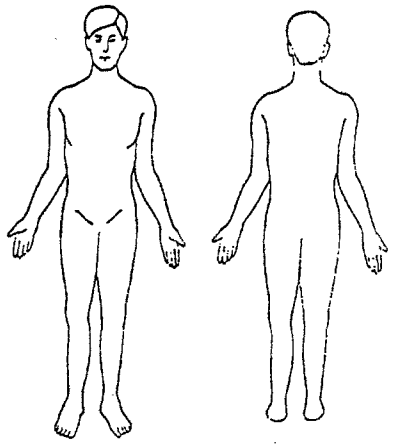
Please indicate if these symptoms are the result of the following:

Auto Accident ( ) **Personal Injury** Other than auto accident ( ) **Work Injury** ( ) **Illness** ( )

When did the accident happen (date): _____
How did this injury occur? (Describe what happened) _____
When did your symptoms begin: _____

Please answer all questions that pertain to today's examination.

YES	NO	Do you experience any of the following?
( )	( )	Previous Surgery to your Abdomen or Pelvis Where: _____ When: _____
( )	( )	Previous Biopsy or Surgery to the Prostate When: _____
( )	( )	Abdominal or Pelvic pain Describe: _____
( )	( )	Abdominal or Pelvic swelling, mass or lump
( )	( )	Loss of appetite
( )	( )	Nausea or vomiting
( )	( )	Chronic Heartburn
( )	( )	Abnormal weight gain or loss
( )	( )	Painful or difficult Urination
( )	( )	Blood in Urine
( )	( )	Urinary retention or inability to control Urination
( )	( )	Urinary frequency or diminished amount of Urine
( )	( )	Constipation or Diarrhea
( )	( )	Blood in Stool
( )	( )	Enlarged Prostate or Prostatitis
( )	( )	History of Prostate Cancer
( )	( )	Enlarged Uterus or Fibroids
( )	( )	History of Uterine or Cervical Cancer



PRE-MENOPAUSAL WOMEN:
• Date of last menstrual period: _____
• Are you taking Birth Control or Hormone Replacement therapy (HRT): _____

Other symptoms or complaints: _____

( ) ( ) Have you had any prior Xrays, CT Scan, Ultrasound or Nuclear Medicine exams for this area?

What Facility: _____

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the MR procedure that I am about to undergo.

Signature: _____ Date: _____