



PELVIS OR ABDOMEN CT/MRI

Name _____
LAST FIRST MIDDLE

Age _____ Date of Birth _____ Today's Date _____

Are you (or do you think you might be) pregnant? _____

Weight _____ Height _____

What was your chief complaint when you visited your doctor? _____

Please circle YES or NO

Have you had nausea or vomiting? YES NO Abnormal bleeding? YES NO

Have you had a change in bowel or bladder habits? YES NO

Have you gained or lost weight? YES NO How much? _____ Time span _____

Do you have discomfort or pain? YES NO Where? _____

Do you have any masses or lumps? YES NO Where? _____

Have you had surgery? YES NO What kind? _____

Have you had abnormal tests (blood work)? YES NO What were they? _____

Have you had a CT scan, MRI scan or any other exam of the affected area? YES NO

If yes, what exam(s)? _____

Are you taking any medications? YES NO What kind? _____

Do you have a personal history of cancer? YES NO What kind? _____

Do you have any other medical conditions? YES NO What condition(s)? _____