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** ( )

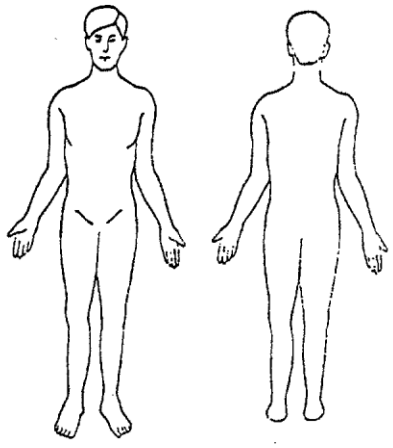
When did the accident happen (date): _____

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



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: _____