

**Eastern Radiologists, Inc. - Greenville MRI  
Abdomen, Pelvis, Heart Questionnaire**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Gender M F

Are you returning to your referring physician today? Y N Date of return: \_\_\_\_\_

Briefly describe your condition and how long you have had these symptoms. \_\_\_\_\_

\_\_\_\_\_

Are the symptoms(circle) BETTER WORSE SAME as when they began?

Have you had any of the following performed on your affected area? If so, please indicate when, where, and brief results.

TEST	When	Hosp/Imaging Center	Results
CT scan			
MRI scan			
Bone scan			
Ultrasound			
Other			

Have you ever had surgery on this area before? YES NO

If yes, when? \_\_\_\_\_

Reason for surgery? \_\_\_\_\_

Where was it done? \_\_\_\_\_

Additional comments: \_\_\_\_\_