EASTERN RADIOLOGISTS
GREENVILLE MRI

2101 W Arlington Blvd, Suite 110, Greenville, NC 27834
Mon–Fri 7am–9pm • Sat / Sun 8am–8pm
252.752.5000 | easternrad.com

Patient Name _____ DOB ___ /___ /___ Date ___ /___ /___ MRN _____

QUESTIONNAIRE: ABDOMEN, PELVIS, HEART

Weight: _____ Height: _____ Gender: Male Female

Are you returning to your referring physician today? Yes No 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: _____

_____

_____