ABDOMEN EVALUATION

Last Name:	First:	Date:

THESE QUESTIONS APPLY ONLY TO THE AREA BEING SCANNED TODAY

1. Have you had an MRI, CT or Ultrasound of your abdomen or pelvis previously? Yes or No (circle one)
   If so, where and when? _____
   What were the results?_____
   _____

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

3. Describe your symptoms:
   _____
   _____

4. What does your doctor think is causing your symptoms?_____

5. How long have you had these symtoms?_____

6. Have you had any bowel or bladder changes? Yes or No (Circle one)

7. Any surgery/arthroscopy on your abdomen or pelvis? Yes or No (Circle one) When? _____
   What was done in surgery? _____

8. Are you currently taking any medications? Yes or No (Circle one) List medications:_____
   _____

9. Do you have any other medical conditions? Yes or No (Circle one) List conditions:_____
   _____

10. Have you ever had cancer? Yes or No (Circle one) If yes, what type?_____
    Have you undergone chemotherapy, radiation therapy or surgery for cancer? Yes or No (Circle one)
    If yes, what type of cancer treatment have you had?_____
    _____
    Dates of cancer treatments:_____

11. Have you had an injury/trauma to the area being scanned today? (e.g. car accident, fall, etc.) Yes or No (Circle one) If yes, date of injury/trauma_____

12. Is there any other information about the area being scanned today that the radiologist should know about?_____
    _____
    _____

Please fill out back of this form

California Advanced Imaging – *Patient History, Safety Screening, and Consent Form*

- Have you ever had metal fragments in your eyes? Yes □ No □
- Do you have any metal fragments in your body? Yes □ No □
- Do you have any prostheses? What type? _____ Yes □ No □
- Have you ever had spine surgery? Date _____ Yes □ No □
- Have you ever had heart surgery? Date _____ Yes □ No □
- Do you have a **pacemaker** or **a cardiac defibrillator**? Yes □ No □
- Do you have a surgically implanted heart valve? Yes □ No □
- Have you ever had brain surgery? Date _____ Yes □ No □
- Do you have brain **(aneurysm)** clips? Yes □ No □
- Have you ever had middle or inner ear surgery? Date _____ Yes □ No □
- Have you ever had eye surgery? Date _____ Yes □ No □
- Do you have an **insulin or medication pump**? Yes □ No □
- Do you wear dentures? Yes □ No □
- Do you wear **hearing aids*?(Remove prior to MRI)*** Yes □ No □
- Do you have on you any magnetically activated device? Yes □ No □
- Do you have any transdermal (medication patches) on you? Yes □ No □
- Do you have permanent make-up (eyeliner, etc.)? Yes □ No □
- Have you or are you using a "pillcam"/M2A endoscopy capsule? Yes □ No □
- ***Females only:*** Is there a chance that you might be pregnant? Yes □ No □

Print Name _____**Age** _____ **Weight** _____

Patient signature _____ **Date** _____

Parent signature (if under 18 years old) _____

Only answer the following questions if you are receiving an IV contrast injection:

Have you ever had MRI contrast? Yes □ No □
Have you had any kind of reaction to contrast? Yes □ No □
If yes please explain: _____
Are you currently breast feeding? Yes □ No □
Are you diabetic? Yes □ No □
Do you have any history of hypertension (high blood pressure)? Yes □ No □
Do you have any history of kidney (renal) insufficiency or failure? Yes □ No □
Do you have a solitary kidney? Yes □ No □
Are you on dialysis? Yes □ No □
Do you have any liver disease? Yes □ No □
Have you had or going to have a liver transplant? Yes □ No □