**Abdomen/Pelvis Evaluation Questionnaire**

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

What complaints or symptoms caused you to see your doctor? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you had these issues? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had **abdomen/pelvic** surgery?  NO  YES If so, What was done?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had any other imaging exams of your **abdomen/pelvic** (MRI, CT, X-Ray, etc.)

If so, What was done and Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Approximate Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ lbs.

**TO ENSURE PROPER COMMUNICATION TO YOUR RADIOLOGIST, PLEASE BE AS SPECIFIC AS POSSIBLE WHEN FILLING OUT THE FOLLOWING PORTION**

 Diarrhea

 Constipation

 Gas Pain /Bloating

 Cancer if so, Where? \_\_\_\_\_\_\_\_\_\_\_

 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Nausea / Vomiting

 Swelling / Mass / Lump

 Irregularity

 Weight Loss

 Rectal Bleeding

 Blood in Urine

 Pain

**For Our Female Patients**

Are you or do you think you may be pregnant?  NO  YES

If you check YES, your exam may be delayed until you can produce a NEGATIVE pregnancy test.

Technologist’s Initials: \_\_\_\_\_\_\_\_\_\_\_\_\_