

# PAIN SHEET

# Pelvis/Lower Abdomen Evaluation

Name			Birth date	Referred by	Today's Date
_____			____/____/____	Dr. _____	____/____/____
Last	First	Middle Init.	mm/dd/yyyy		mm/dd/yyyy

1. Have you had a pelvic CT or sonogram (ultrasound) before? \_\_\_\_\_  
If yes, when? \_\_\_\_\_ What did it show? \_\_\_\_\_

2. What do you think caused the problem? \_\_\_\_\_

3. What does your doctor say about what he/she thinks may be causing your problem? \_\_\_\_\_

4. Describe your symptoms (pain, mass, weight change, etc.) \_\_\_\_\_

5. Does anything make the symptoms worse? \_\_\_\_\_

Does anything make them better? \_\_\_\_\_

6. Have you had lower abdominal or pelvic surgery? \_\_\_\_\_

If yes, when? \_\_\_\_\_ What was done? \_\_\_\_\_

7. Are you taking any medicines? \_\_\_\_\_

What kind? \_\_\_\_\_

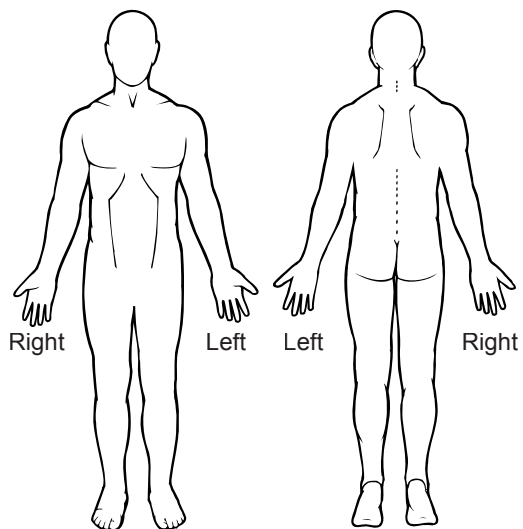
8. Do you have any other medical conditions? \_\_\_\_\_

If so, what? \_\_\_\_\_

9. Describe your general health: \_\_\_\_\_

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

Please indicate the area of interest, the location of any mass, or any area that hurts...



Please complete BOTH sides.

Patient History and Safety Screening  
*MRI PATIENTS ONLY*

**Please answer all of the following questions:**

YES    NO

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | CARDIAC PACEMAKER                                      |
| <input type="checkbox"/> | <input type="checkbox"/> | BRAIN VESSEL CLIPS                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | AORTIC CLIPS   |
| <input type="checkbox"/> | <input type="checkbox"/> | ARTIFICIAL HEART VALVE                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | CORONARY, ARTERY OR HEART SURGERY, IF YES, WHEN? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | INSULIN PUMP   |
| <input type="checkbox"/> | <input type="checkbox"/> | ELECTRODES   |
| <input type="checkbox"/> | <input type="checkbox"/> | TENS UNITS OR PAIN STIMULATING UNIT                    |
| <input type="checkbox"/> | <input type="checkbox"/> | EAR SURGERY OR IMPLANTS                                |
| <input type="checkbox"/> | <input type="checkbox"/> | HEARING AIDS   |
| <input type="checkbox"/> | <input type="checkbox"/> | METAL FRAGMENTS IN THE HEAD, EYE OR SKIN               |
| <input type="checkbox"/> | <input type="checkbox"/> | HAVE YOU EVER WORKED WITH METAL OR AS A METAL WORKER?  |
| <input type="checkbox"/> | <input type="checkbox"/> | METAL PLATES, PIN, SCREWS, NAILS OR CLIPS              |
| <input type="checkbox"/> | <input type="checkbox"/> | ANY PREVIOUS SKULL SURGERY                             |

If yes, what was the surgery for: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | IS THERE ANY CHANCE YOU ARE PREGNANT?<br>(Not recommended for women in their first trimester of pregnancy) |
|--------------------------|--------------------------|--|

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Signature of patient: \_\_\_\_\_

Signature of parent or guardian: \_\_\_\_\_

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

**Please complete BOTH sides**