

**CLINICAL INFORMATION SHEET
ABDOMEN AND PELVIS**

Name _____ Age _____ Today's Date _____

1. Why are you having this test? _____

2. Do you have abdominal pain? _____ Where: _____

a. Is the pain related to certain foods? _____ Which: _____

b. Does the pain wake you up at night? _____

c. Is the pain burning, knife like, gnawing, uncomfortable? Please explain: _____

3. Please check if you have any of the following:

Nausea _____ Vomiting _____ Blood _____

Heartburn _____ Gas or bloating _____ Trauma _____

Weight Loss _____ Diarrhea _____ Constipation _____

Kidney Stones _____ Jaundice _____ Blood In Urine _____

Cancer _____ What Kind? _____ Abnormal Blood Test _____

Rectal Bleeding? _____

4. Have you had any surgery to your abdomen or pelvis? _____

5. Do you still have your appendix? _____

6. Do you feel like food gets caught in your throat? _____

7. Have you had a previous CAT scan, MRI, sonogram or other test which may help interpret this exam? _____

If yes, explain _____ Where? _____ When? _____

8. Is there any other information you might find helpful? _____