

Trinitas Diagnostic Imaging

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www.TrinitasDiagnosticImaging.com

Pelvis Questionnaire - Male

If you're coming to our center for this test, print this page, fill out the form and bring it in with you on the day of your appointment.

FIRST NAME

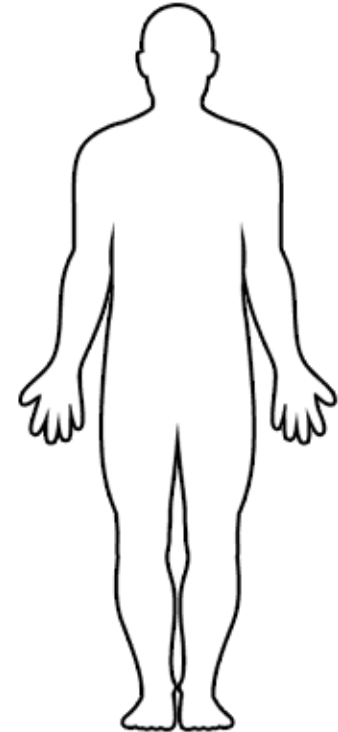
LAST NAME

AGE

WEIGHT

DATE

WHAT WAS YOUR CHIEF COMPLAINT WHEN YOU VISITED YOUR DOCTOR?



Please circle the portion of your body that is in pain.

WHICH AREA IS AFFECTED? LEFT CENTRAL RIGHT

ANY HISTORY OF CANCER? YES NO

IF YES, WHERE?

HOW LONG HAVE YOU HAD THIS PROBLEM?

ANY SURGERY OF THE PELVIS? YES NO

IF YES, WHEN AND WHAT WAS DONE?

ANY PROSTATE SURGERY? YES NO

ARE YOU RECEIVING HORMONAL THERAPY ? YES NO

ANY OTHER MEDICAL CONDITIONS? YES NO

DESCRIBE YOUR GENERAL HEALTH?