



Housatonic Valley Radiological Associates

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Community Based Imaging Excellence for Over 25 Years

Accredited by the American College of Radiology

BRAIN MRI QUESTIONNAIRE

Name _____ Acct # _____
Date of Birth _____ SS# _____ Sex (M/F) _____ Age _____

Pertaining to your BRAIN, have you ever had...

Previous MRI? _____ Where: _____ When: _____

Previous CT Scan? _____ Where: _____ When: _____

Background / Symptoms:

Are your Right or Left handed? RIGHT LEFT

Do you have.....

Headaches?	YES	NO	Dizziness?	YES	NO
Seizures?	YES	NO	Numbness?	YES	NO
Weakness?	YES	NO	Difficulty Walking?	YES	NO
Decreased Vision?	YES	NO	Decreased Hearing?	YES	NO
Double Vision?	YES	NO	Ringing in Ears?	YES	NO
Which Eye?	Right	Left	Which Ear?	Right	Left

Do you have any major medical problems? (cancer, diabetes, lung problems, etc.) YES NO

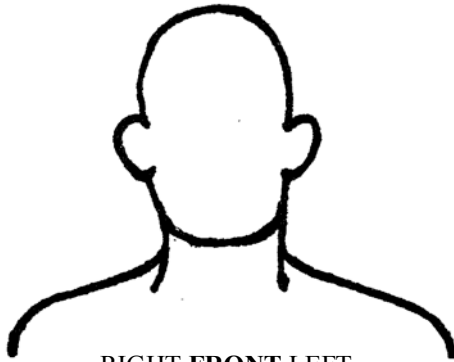
If YES, please describe: _____

Have you had surgery on the body part being imaged? YES NO

If YES, which facility _____ By Whom _____ When _____

Do you take medication? YES NO What kind? _____

Please shade in area(s) of pain:



RIGHT FRONT LEFT



LEFT BACK RIGHT