

Community Based Imaging Excellence for Over 30 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

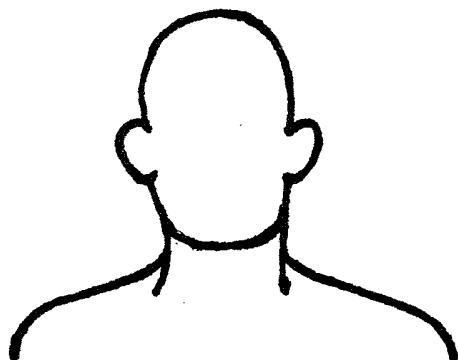
If YES, please describe: \_\_\_\_\_

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

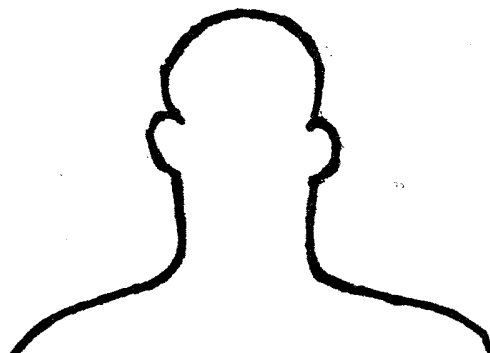
If YES, which facility \_\_\_\_\_ By Whom \_\_\_\_\_ When \_\_\_\_\_

Do you take medication?    YES    NO                      What kind? \_\_\_\_\_

Please shade in area(s) of pain:



**RIGHT FRONT LEFT**



**LEFT BACK RIGHT**