

HILLSBOROUGH RADIOLOGY ASSOCIATES, P.A.
MRI QUESTIONNAIRE-HEAD/BRAIN

NAME: _____ D.O.B: ____/____/____
 (Last) (First)
 AGE: _____ SEX: M / F WEIGHT: _____ HEIGHT: ____ ft. ____ in.

REFERRING PHYSICIAN: _____

- What type of problem are you having? _____
- Was this a result of an injury? _____
- How long have you had this problem? _____
- Do you have a history of being diagnosed with cancer? Yes ____ No ____ Type _____
- Have you been treated with either radiation or chemotherapy? (If yes, circle) Date completed _____
- Have you had brain surgery? Yes ____ No ____ If yes, when _____

Do you have, or have you ever had, any of the following? (If yes, circle)

- | | | |
|---|-------------------------------------|----------------|
| PACEMAKER/DEFIBRILLATOR | METAL SLIVERS IN EYES | IUD |
| DIABETES or KIDNEY DISEASE | SHRAPNEL (bomb or bullet fragments) | HEARING AID |
| COCHLEAR IMPLANTS | BREAST TISSUE EXPANDER | BODY PIERCING |
| HEART VALVE REPLACEMENT | NEURO STIMULATOR | PENILE IMPLANT |
| TATOOS (over 20 years old) | PESSARY (bladder support) | ANEURYSM CLIPS |
| REMOVABLE DENTAL WORK/DENTURES | | |
| ENDOSCOPY CLIPS/INGESTED PILL CAMERA/PH BRAVO CAPSULE | | |
| MEDICATION PATCH (birth control/nicotine/Nitroglycerine) | | |
| ANY EXTERNAL/INTERNAL PUMPS (i.e., Insulin, chemotherapy) | | |

Have you had any imaging studies of your head or neck? Yes ____ No ____

Type of study _____ Where _____ When _____

DO YOU HAVE ANY HISTORY OF:

Brain Aneurysm	Yes ____	No ____	Loss of Hearing	R ____	L ____
Stroke	Yes ____	No ____	Arm Weakness	R ____	L ____
Seizures	Yes ____	No ____	Leg Weakness	R ____	L ____
Trauma	Yes ____	No ____	Loss of Balance	Yes ____	No ____
Dizziness	Yes ____	No ____	Memory Loss	Yes ____	No ____
Cerebral Arteriogram	Yes ____	No ____	Facial Pain	Yes ____	No ____
Blurred Vision	Yes ____	No ____	Sinus Trouble	Yes ____	No ____
High Blood Pressure	Yes ____	No ____	Headaches or Fever	Yes ____	No ____

1. If Yes, briefly describe _____

- Do you have a history of allergies? Yes ____ No ____ If so, what kind? _____
- Are you pregnant, or is there a possibility that you might be pregnant? Yes ____ No ____

I acknowledge that all the information given is accurate and thereby consent to have Magnetic Resonance Imaging with or without an injection of contrast performed on me. I do not have a pacemaker. I have removed all hearing aids and dentures and any external pumps and monitoring devices..

 Signature of Patient or Legal Guardian Date: ____/____/____ Technologist's Initials: _____

Technologist to Complete the Section Below

MR # _____ Designated Physician On-Site: _____
 Tech: _____ Supervising Physician (if different): _____
 Contrast Used: **OPTIMARK** / _____ mls Lot # _____