MRI QUESTIONNAIRE – **BRAIN/HEAD**

NAME: _____ D.O.B:___/____/___ AGE: ____ SEX: M/ F
(Last) (First)

WT: ____ lbs HT:___ft.___in REFERRING PHYSICIAN:_____

- Please provide a summary of your symptoms specific to your exam today? _____

  _____
- The symptoms primarily involve what part of your body? _____

  If applicable, please circle: RIGHT or LEFT or BOTH sides of your body and/or UPPER or LOWER part of abdomen.
- Did this symptom/condition arise suddenly? Yes ___ No ___ When did the problem start? _____
- How long have you been treated for this problem? _____ Circle if problem is: Chronic or Acute or Temporary
- Is this your initial visit or follow-up visit? _____
- What is/was the cause of the problem? Accident Motor Vehicle Fall Work-Related Injury (Complete injury form)
- Are you having any pain? Yes___ No___ If Yes, circle if pain is severe or moderate or mild.

  If Yes, circle if pain is generalized or localized. If localized pain, describe specific area of pain? _____
- Do you have any swelling or bruising or inflammation or contusion or sprain or open wound (please circle, if applicable)?
- Did any existing disease/condition attribute to this current symptom/condition? _____
- Do you have a history of being diagnosed with cancer? Yes___ No____ When? _____ Type _____
- Have you been treated with either Radiation or Chemotherapy? (If yes, circle) Date Started _____ Completed _____
- Any surgery on area to be imaged? Y____ N____ If Yes, when and what type? _____

DO YOU HAVE ANY HISTORY OF:

- Brain Aneurysm Yes___ No____ Loss of Hearing R___ L____ Cerebral Arteriogram Yes___ No____
- Stroke Yes___ No____ Arm Weakness R___ L____ Facial Pain Yes___ No____
- Seizures Yes___ No____ Leg Weakness R___ L____ Blurred Vision Yes___ No____
- Trauma Yes___ No____ Loss of Balance Yes__ No___ Sinus Trouble Yes___ No____
- Dizziness Yes___ No____ Memory Loss Yes__ No___ Fever Yes___ No____
- Headaches Yes___ No____ High Blood Pressure Yes___ No____

  If Yes, briefly describe_____
- Any other medical or family history pertaining to your exam being performed today? _____
- **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		**STENTS**
ENDOSCOPY CLIPS/INGESTED PILL CAMERA/PH BRAVO CAPSULE		**BRACES**
MEDICATION PATCH (birth control/nicotine/Nitroglycerine)		**HISTORY OF EAR TUBES**
ANY EXTERNAL/INTERNAL PUMPS (i.e., Insulin, chemotherapy)		

- Have you ever had a CT Scan, Ultrasound or any other imaging studies done of the area being scanned? Yes____ No_____
  If yes, what test/what area? _____
- Are you pregnant or possibly pregnant? Yes___ No___ Do you have a history of allergies? Yes____ No____
  If so, what kind? _____

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, dentures, any external pumps and monitoring devices.

_____ **Date:**___/____/____ **Technologist Initials:** _____
Patient's Signature