



MRI QUESTIONNAIRE-HEAD/BRAIN

NAME: _____ D.O.B: ___/___/___
(Last) (First)

AGE: _____ SEX: M/ F WEIGHT: _____ HEIGHT: _____ ft. _____ in MR#: _____

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)**
 - PACE MAKER** **METAL SLIVERS IN EYES**
 - ANEURYSM CLIPS** **SHRAPNEL (bomb or bullet fragments)**
 - COCHLEAR IMPLANTS** **HEARING AID**
 - HEART VALVE REPLACEMENT** **REMOVEABLE DENTAL WORK/DENTURES**
 - NEURO STIMULATOR** **TATOO'S (over 20 yrs old)**
 - BODY PIERCING** **PENILE IMPLANT**
- 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 ___

If Yes, briefly describe _____

- **Are you pregnant, or is there a possibility that you might be 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 performed on me.

I do not have a pacemaker. I have removed all hearing aids and dentures.

Date: ___/___/___

Patient's Signature

Technologist to Complete Below this Line

Rad authorizing IV Contrast: _____ Tech: _____ Study Protocolled By: _____
 Contrast Used: _____/_____ cc's Lot#: _____ Study Checked By: _____