HILLSBOROUGH RADIOLOGY ASSOCIATES

MRI QUESTIONAIRE-**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)**

PACE MAKER/DEFIBRILLATOR	**METAL SLIVERS IN EYES**
ANEURYSM or ENDOSCOPY CLIPS	**SHRAPNEL (bomb or bullet fragments)**
COCHLEAR IMPLANTS	**HEARING AID**
HEART VALVE REPALCEMENT	**REMOVEABLE DENTAL WORK/DENTURES**
NEURO STIMULATOR	**TATOO'S (over 20 yrs old)**
BODY PIERCING	**PENILE IMPLANT**
DIABETES or KIDNEY DISEASE	**MEDICATION PATCH (Birth Control/Nicotine/Nitrogylcerine)**

- Have you had any **imaging** studies of your head or neck? If yes, what 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 with or without an injection of contrast performed on me. I do not have a pacemaker. I have removed all hearing aids and dentures.

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

TECHNOLOGIST TO COMPLETE Below This Line

Rad authorizing IV Contrast: _____ Tech: _____ Study **Protocoled** by: _____

Contrast used (circle): **OptiMark** Volume: _____ cc's Lot#: _____ Study **Checked** by: _____