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____
- Stroke Yes___ No____
- Seizures Yes___ No____
- Trauma Yes___ No____
- Dizziness Yes___ No____
- Headaches Yes___ No____

Loss of Hearing R___ L____
Arm Weakness R___ L____
Leg Weakness R___ L____
Loss of Balance Yes__ No___
Memory Loss Yes__ No___

Cerebral Arteriogram Yes___ No____
Facial Pain Yes___ No____
Blurred Vision Yes___ No____
Sinus Trouble Yes___ No____
Fever 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
DIABETES or KIDNEY DISEASE
COCHLEAR IMPLANTS
HEART VALVE REPLACEMENT
TATOOS (over 20 years old)
REMOVABLE DENTAL WORK/DENTURES
METAL SLIVERS IN EYES
SHRAPNEL (bomb or bullet fragments)
BREAST TISSUE EXPANDER
NEURO STIMULATOR
PESSARY (bladder support)
IUD
HEARING AID
BODY PIERCING
PENILE IMPLANT
ANEURYSM CLIPS
STENTS
BRACES
HISTORY OF EAR TUBES
ENDOSCOPY CLIPS/INGESTED PILL CAMERA/PH BRAVO CAPSULE
MEDICATION PATCH (birth control/nicotine/Nitroglycerine)
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___ Have you ever had a reaction to MRI contrast ? Yes___ No___
  If yes, what type of reaction? _____

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