

MRI BRAIN

Name _____ Date _____

Age _____ Weight _____

Please give a brief description of your symptoms related to the area to be scanned:

Are you having headaches? Yes ___ No ___

If yes, give location, duration, and length of time you have had headache.

Have you had any surgeries or any confirmed abnormalities of the brain?

Do you have any of the following symptoms?

	Yes	No	Description
Hearing loss	___	___	_____
Tinnitus	___	___	_____
Dizziness (vertigo)	___	___	_____
Weakness	___	___	_____
Stroke	___	___	_____
Vision problems	___	___	_____
History of cancer or tumor	___	___	_____
Loss of function of legs or arms	___	___	_____
Numbness in legs or arms	___	___	_____
Memory loss	___	___	_____
Pituitary gland tumor	___	___	_____
Any other symptoms	___	___	_____

Prior scans (for the area being scanned today):

CT	Yes ___ No ___	When _____	Where _____
MRI	Yes ___ No ___	When _____	Where _____
X-ray	Yes ___ No ___	When _____	Where _____
Nuc medicine	Yes ___ No ___	When _____	Where _____

Technologist: _____