MRA OF HEAD OR NECK

Patient Name: ______________________________ Date: _______________

Age: ________ Weight: _______

Give a brief description of your problems.

____

____

Do you have?	Yes	No
Dizziness	___	___
Numbness		
Right side	___	___
Left side	___	___
Memory loss	___	___
Head aches	___	___
Hearing loss	___	___

Other symptoms ____

Any other exams positive for the present symptoms?

____

Any surgeries in the area to be examined today? _____________________________

____

Technologist: _____________________