Patient Questionnaire for MRI Brain/MRA Head and Neck/MRV Head

Patient Name: _____

Patient Account Number: _____ Patient DOB: _____

Patient Weight (lbs): _____ Height: _____feet_____inches

Please check all problems which you have

Weakness of one side of your body? _____ Which side? _____ Which part? _____

Numbness of one side of your body? _____ Which side? _____ Which part? _____

Tingling of one side of your body? _____Which side? _____ Which part? _____

Weakness of your face? _____

Temporary loss of vision? _____

Sudden loss of vision? _____

Double vision? _____

Other vision problems? _____

Passed out/Loss of consciousness? _____

Problems speaking? _____

Sudden loss of hearing? _____

Loss of coordination? _____

Migraine headaches? _____

Blocked blood vessel in neck or head? _____

Head injury? _____

Bleeding in your head? _____

Brain tumor? _____

Aneurysm in head? _____

Is there anything else you think we should know that would help us understand your problem?

_____

_____

Previous MRI of the brain? ◯ yes ◯ no

Name of Facility : _____

Date of Exam: _____