# HEAD/BRAIN
# MRI QUESTIONNAIRE

**PATIENT WEIGHT**__________ **PATIENT HEIGHT**__________

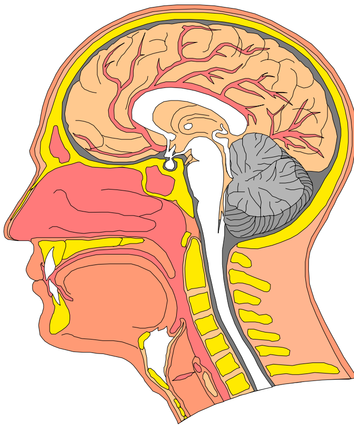
**INJURY**

Work-related Injury _____ Yes _____ No
Motor Vehicle Accident _____ Yes _____ No
Sports Injury _____ Yes _____ No
Date of Injury_____________________________________________________________
**Describe Injury**___________________________________________________________

**SYMPTOMS**

Headache _____ Acute _____ Chronic
Frequency/Duration__________________________________________________________
For each symptom checked below, please describe:
_____ History of trauma, concussions____________________________________________
_____ Fever ______________________________________________________________
_____ Sinusitis_____________________________________________________________
_____ Nausea______________________________________________________________
_____ Dizziness____________________________________________________________
_____ Vomiting ____________________________________________________________
_____ Seizures (etiology unknown) _____________________________________________
_____ Speech difficulty ______________________________________________________
_____ Eye muscle weakness___________________________________________________
_____ Hearing loss _________________________________________________________
_____ Numbness/tingling sensations ____________________________________________
_____ Cognitive difficulties___________________________________________________
_____ Visual disturbance (double vision, blurred vision)___________________________
_____ Facial irritation/pain ___________________________________________________
_____ Motor function disturbance (weakness, sensory changes) ______________________
How long have you had the above symptoms?______________________________________
_____ History of medical disease (Parkinson's Disease, Arthritis, etc.)
**Please describe** _________________________________________________________
_____ History of cancer (please indicate primary cancer)
**Please describe** _________________________________________________________

Please indicate below where pain is located.



**PREVIOUS STUDIES PERTAINING TO CURRENT PROBLEM**

| | | | | |
|---|---|---|---|---|
| X-Rays | Yes | No | Where_________________ | Date_______________ |
| CT Scan | Yes | No | Where_________________ | Date_______________ |
| MRI Scan | Yes | No | Where_________________ | Date_______________ |
| Brain Surgery | Yes | No | Where_________________ | Date_______________ |

What was done? (please specify)_______________________________________________

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**Technologist Use:** **Technologist** _________________________ **Date** _______________
*Contrast:* ___________cc of ____________________ (type) injected into _____________________ (area).
**Notes/Complications**

_______________________________________________________________________________
_______________________________________________________________________________
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