

MRI PATIENT QUESTIONNAIRE
BRAIN

NAME: _____ DATE: _____

WHAT PROBLEMS ARE YOU HAVING THAT LED YOU TO HAVING THIS
SCAN? _____

DO YOU HAVE PAIN, NUMBNESS, OR WEAKNESS? _____
WHERE? _____

HAVE YOU HAD ANY OF THE FOLLOWING?

PLEASE CHECK ALL THAT APPLY

HEADACHES__ VERTIGO__ SEIZURES__

CONVULSION__ DIZZINESS__ SYNCOPE__

BLACKOUTS__ SPEECH DISORDER__

LOSS OF VISION__ MEMORY LOSS__

FORGETFUL__ BEHAVIORAL CHANGES__

STROKE__ WHEN? _____

HEAD TRAUMA__ WHEN? _____

HAVE YOU HAD ANY TYPE OF BRAIN SURGERY? _____

WHAT TYPE? _____ WHEN? _____

ANY HISTORY OF CANCER, RADIATION, OR CHEMOTHERAPY? _____

WHAT TYPE? _____ WHEN? _____

DO YOU HAVE ANY OTHER MEDICAL PROBLEMS? _____
