

Delaney Radiologists

MRI BRAIN PATIENT HISTORY

Date: _____

Delaney No. _____

Name: _____ Sex: M F Age: _____

PLEASE TRY TO ANSWER ALL QUESTIONS

What is your present complaint or problem?

About how long ago did it start? _____

Have you had a previous related MRI or CT scan? Yes No

If yes, when? _____ Where? _____

If yes, what were the results? _____

Have you ever had a significant head injury that required hospitalization? Yes No

If yes, when? _____ Where? _____

Do you take medication for high blood pressure? Yes No

If yes, please list: _____

Do you have a history of cancer? Yes No

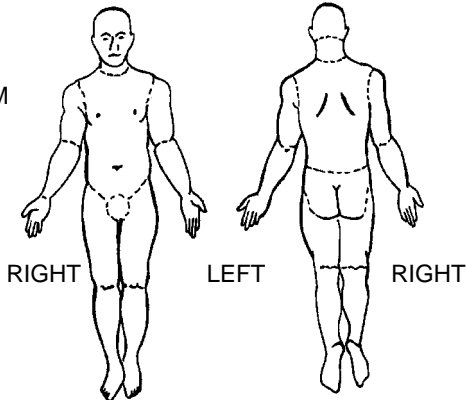
If yes, what type?: _____

Please check beside the following symptoms from which you suffer:

- Headache
- Migraine
- Seizures
- Confusion
- Difficulty Walking
- Difficulty Speaking
- Vision Problems
- Hearing Loss
- Black Outs
- Dizziness
- Tremors
- Shaking

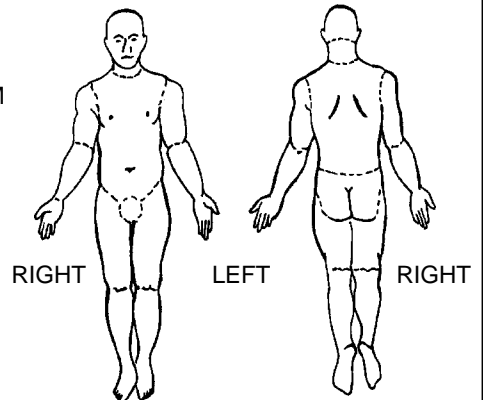
Numbness

ON THE DIAGRAM TO THE RIGHT, PLEASE SHADE THE AREAS OF NUMBNESS.



Weakness

ON THE DIAGRAM TO THE RIGHT, PLEASE SHADE THE AREAS OF WEAKNESS.



Patient Signature _____ Date _____

Technologist Signature _____ Date _____