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 ❑

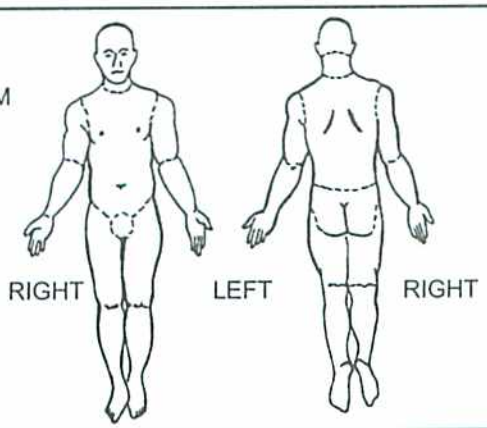
If yes, what type?: _____

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

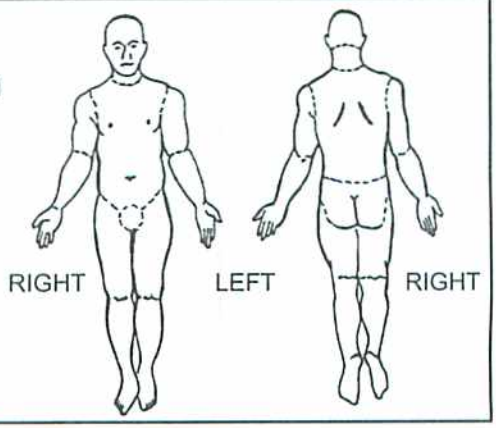
❑ Numbness

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 _____