

PREMIER MRI 4 U
M.R.I. BRAIN QUESTIONNAIRE

Patient Name: _____ **Date:** _____

PLEASE ANSWER THE FOLLOWING QUESTIONS AS THEY WILL HELP THE RADIOLOGIST INTERPRET YOUR EXAM.

1. Within the past **two weeks**, have you had any of the following: CHECK ONE:
- | | | |
|-----------------------|-----|----|
| 1. Seizures | YES | NO |
| 2. Dizziness | YES | NO |
| 3. Blurred Vision | YES | NO |
| 4. Severe Headaches | YES | NO |
| 5. Elevated Prolactin | YES | NO |
| 6. Difficulty Hearing | YES | NO |
- Which ear:* Left Right
2. Have you ever had a stroke? YES NO
If "YES", what side of your body was affected? Right Left
3. Have you ever had loss of vision? YES NO
If "YES", what side of your body was affected? Right Left
4. Do you have high blood pressure? YES NO
If "YES", are you being treated? YES NO
5. Have you ever had cancer or a tumor? YES NO
If "YES", what type of cancer? _____
6. Have you ever undergone radiation therapy? YES NO
7. Have you ever had brain, head or facial surgery? YES NO
8. Please describe any other problem(s) you are having.

Patient Signature: _____ **Date:** _____
If patient is a minor, then parent or legal guardian signature