



iCare Diagnostic Imaging, LLC
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HEAD/BRAIN MRI QUESTION- NAIRE

PATIENT WEIGHT _____ PATIENT HEIGHT _____

INJURY

Work-related Injury _____ Yes _____ No
 Motor Vehicle Accident _____ Yes _____ No
 Sports Injury _____ Yes _____ No

Date of Injury _____

Describe Injury _____

Please indicate below where pain is located.

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 _____

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) _____

Technologist Use: Technologist _____ Date _____

Contrast: _____ cc of _____ (type) injected into _____ (area).

Notes/Complications

