HTPN DALLAS DIAGNOSTIC ASSOCIATION

MAGNETIC RESONANCE IMAGING (MRI)
HEAD QUESTIONNAIRE

Print Name:_____ **Date:**_____

1.) Within the past month, have you experienced any of the following symptoms:

	Yes	No
a. seizures	☐	☐
b. dizziness	☐	☐
c. blurred vision	☐	☐
d. difficulty hearing	☐	☐
e. elevated prolactin level	☐	☐
f. headaches	☐	☐

2) Reason you are having this MRI scan, include any recent or new complaints:_____
_____

3) Have you ever had a stroke? ☐ Yes ☐ No
If yes, when?_____ What part of your body was affected?_____

4) Have you had a loss of vision? ☐ Yes ☐ No
If yes, when?_____ Which eye was affected? ☐ Right ☐ Left ☐ Both

5) Do you have a history of cancer?_____ If yes, what type?_____
Did the treatment include:
Radiation Therapy? ☐ Yes ☐ No
Chemotherapy? ☐ Yes ☐ No
If yes to Radiation Therapy, what part of your neck or back? If yes, when?_____

6) Have you had surgery on any part of your head?_____ If yes, date of surgery:_____
Type of surgery?_____

7) Do you have any chronic or long term illnesses?_____

8) Have you had any other types of previous surgery?_____ If yes, list the type of surgery and date:
_____ _____
_____ _____

9) Have you had any previous imaging studies of your head? ☐ Yes ☐ No
* If yes, please indicate:

Type of Study:	**Date**	**Facility**
Radiographs (X-rays)	_____	_____
Angiogram	_____	_____
Computed Tomography (CT)	_____	_____
Bone Scan (Nuclear Medicine)	_____	_____
MRI	_____	_____
Other	_____	_____

MRI Technologists Notes:

_____
_____
_____

Perfusion Slices: Perfusion protocol provided by: _____M.D.
Start: Inferior / Superior position: _____
End: Inferior / Superior Position: _____