Pembina High-Field MRI

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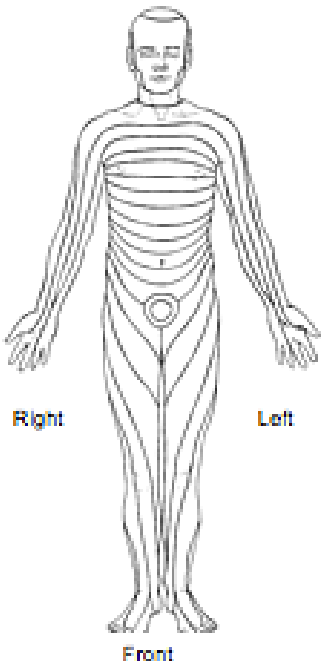
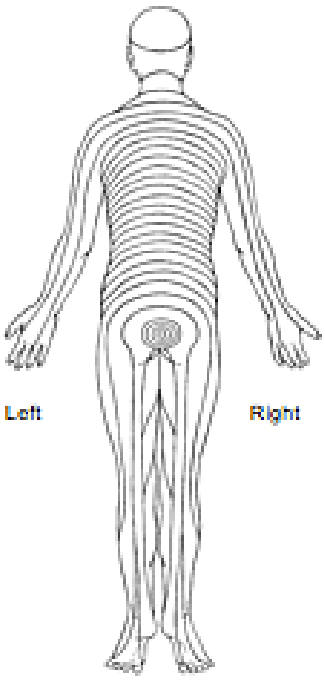
Patient History Sheet: Head





Name: _____ **Date of Exam:** _____

Gender: ❑ Male ❑ Female **Date of Birth:** _____

Was the onset of your symptoms related to an injury? ❑ Yes ❑ No

If yes, how and when? _____

Symptoms:
How long have you had your symptoms? _____

Please give a description of your symptoms (be thorough): _____

_____

Please check the area(s) affected below and shade affected area(s) to the left. If you answer yes to any of the symptoms below, please tell how long you have had them in the space at the right.

Headaches	❑ Yes	❑ No	_____
Slurred speech	❑ Yes	❑ No	_____
Dizziness	❑ Yes	❑ No	_____
Double vision	❑ Yes	❑ No	_____
Hearing loss	❑ Yes	❑ No	_____
Tinnitis (ringing in the ears)	❑ Yes	❑ No	_____
Weakness	❑ Yes	❑ No	_____
Numbness/tingling	❑ Yes	❑ No	_____
Facial droop	❑ Yes	❑ No	_____
Seizures	❑ Yes	❑ No	_____
History of hypertension	❑ Yes	❑ No	_____
History of diabetes	❑ Yes	❑ No	_____
History of contrast reaction	❑ Yes	❑ No	_____
Pain	❑ Yes	❑ No	_____
Do you have a mass/lump	❑ Yes	❑ No	_____
Fever/chills	❑ Yes	❑ No	_____
Have you ever been a smoker	❑ Yes	❑ No	_____
Any history of cancer	❑ Yes	❑ No	Type: _____

If yes, when was it diagnosed? _____

How was it treated? ❑ Radiation therapy ❑ Chemotherapy ❑ Surgery

Have you ever had surgery on your head before? ❑ Yes ❑ No

If yes, when? _____ What was done? _____

Previous Brain Studies:

Bone scan:	❑ Yes	❑ No	Where:_____	Date:_____
X- Rays:	❑ Yes	❑ No	Where:_____	Date:_____
CT scan:	❑ Yes	❑ No	Where:_____	Date:_____
CT Angiogram:	❑ Yes	❑ No	Where:_____	Date:_____
Angioplasty/Angiogram:	❑ Yes	❑ No	Where:_____	Date:_____
MRI Brain:	❑ Yes	❑ No	Where:_____	Date:_____
MRI Angio:	❑ Yes	❑ No	Where:_____	Date:_____