Screening Sheet for MRI of the Brain

Name:_____ Date:_____

1) What was your chief complaint when you visited the doctor?_____

_____

_____

2) Do you have headaches? YES NO

Describe your headaches:_____

_____

Have you had any changes in your vision or experienced double vision? YES NO

Have you experienced ringing in your ears or hearing loss? YES NO

Do you have a history or seizures? YES NO

Have you had a problem with slurred speech or difficulty talking? YES NO

Have you had any facial numbness? YES NO

Have you had a problem with fainting or blacking out? YES NO

Do you have a family history of cerebral aneurysms? YES NO

Do you have a family history of migraine headaches? YES NO

Any related medical conditions/symptoms:_____

_____

_____

_____

_____

Date of exam:_____

MR#:_____