O P E N
ADVANTAGE
M R I
We scan with compassion

MRI Patient Clinical History
Brain

Name: _____ Date: _____

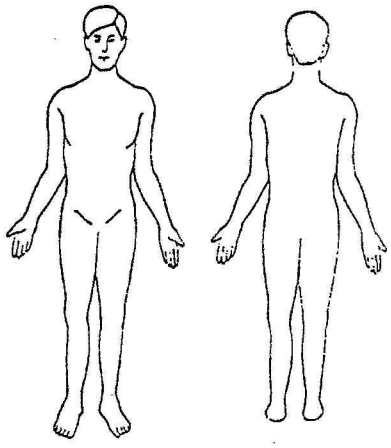
Please indicate if these symptoms are the result of the following:

Auto Accident ( ) Injury ( ) Illness ( )

When did your symptoms start or accident happen: _____

Please answer all questions that pertain to today's examination.

YES	NO	Do you experience any of the following?		
( )	( )	Previous Surgery to the head or brain		
		Where: _____ When: _____		
( )	( )	Recent trauma / injury to the head		
		Where: _____ When: _____		
( )	( )	Headache		
		Where: _____		
( )	( )	Symptoms started suddenly		
( )	( )	Symptoms come and go		
( )	( )	Symptoms are constant		
( )	( )	History of Multiple Sclerosis		
( )	( )	History of High Blood Pressure		
( )	( )	Seizures, Convulsions or Epilepsy		
( )	( )	Fainting or blackouts		
( )	( )	Dizziness or Light - Headedness		
( )	( )	Hearing difficulty or loss	Right ear	Left ear
( )	( )	Ringing or other noises	Right ear	Left ear
( )	( )	Blurred or double vision	Right eye	Left eye
( )	( )	Sudden vision loss	Right eye	Left eye
( )	( )	Difficulty speaking or writing		
( )	( )	Slurred speech		
( )	( )	Paralysis of arm or leg	Right	Left
( )	( )	Difficulty in walking or abnormal gait		
( )	( )	Tremor, Spasm. Facial tic or facial pain		
		Where: _____		
( )	( )	Swelling, mass or lump in head or neck		



Other symptoms or complaints: _____

( ) ( ) Have you had any prior Xrays, CT Scan, Ultrasound or Nuclear Medicine exams for this area?

Where: _____

( ) ( ) Have you had cancer? Type: _____

What was done? Surgery Chemotherapy Radiation Therapy

Date of Surgery: _____ Date of therapy: _____