

**HIC HENRY COUNTY  
MC MEDICAL CENTER**

Imaging 731-644-8480 Scheduling 731-644-8486  
www.hcmc-tn.org

**MRI/MRA QUESTIONNAIRE-  
HEAD/BRAIN**

NAME: \_\_\_\_\_ D.O.B: \_\_\_/\_\_\_/\_\_\_ MR# \_\_\_\_\_

AGE: \_\_\_\_\_ SEX: M/F WEIGHT: \_\_\_\_\_ HEIGHT: \_\_\_ft. \_\_\_in.

REFERRING PHYSICIAN: \_\_\_\_\_

- What type of problem are you having? \_\_\_\_\_
- Was this a result of an injury? \_\_\_\_\_
- How long have you had this problem? \_\_\_\_\_
- Do you have a history of being diagnosed with cancer? Yes \_\_\_ No \_\_\_ Type \_\_\_\_\_
- Have you had a stent placement within the last 8 weeks? Yes \_\_\_ No \_\_\_ If yes, when? \_\_\_\_\_
- Have you been treated with either Radiation or Chemotherapy? (If yes, circle) Date Completed \_\_\_\_\_
- Do you have diabetes or any diseases that affect your blood or a history of renal disease? Yes \_\_\_ No \_\_\_
- Have you had Brain Surgery? Yes \_\_\_ No \_\_\_ If yes, when? \_\_\_\_\_
- Do you have any internal devices or objects implanted in your body? Yes \_\_\_ No \_\_\_ If yes, please describe \_\_\_\_\_
- Do you have any artificial or prosthetic limbs? Yes \_\_\_ No \_\_\_ If yes, please list \_\_\_\_\_
- Do you have a history of contrast reaction or latex allergy? Yes \_\_\_ No \_\_\_ If so, what kind? \_\_\_\_\_
- Are you pregnant, breastfeeding or is there a possibility that you might be pregnant? Yes \_\_\_ No \_\_\_

Do you have, or have you ever had any of the following? (If yes, circle)

- |                                |  |
|--------------------------------|--|
| <b>PACE MAKER</b>              | <b>METAL SLIVERS IN EYES</b>               |
| <b>ANEURYSM CLIPS</b>          | <b>SHRAPNEL (bomb or bullet fragments)</b> |
| <b>COCHLEAR IMPLANTS</b>       | <b>HEARING AID</b>                         |
| <b>HEART VALVE REPLACEMENT</b> | <b>REMOVABLE DENTAL WORK/DENTURES</b>      |
| <b>BONE ORNEURO STIMULATOR</b> | <b>CARDIAC DEFIBRILLATOR</b>               |
| <b>BODY PIERCING</b>           | <b>PENILE IMPLANT</b>                      |

Have you had any imaging studies of your head or neck? Yes \_\_\_ No \_\_\_

Type of study \_\_\_\_\_ Where \_\_\_\_\_ When \_\_\_\_\_

**DO YOU HAVE ANY HISTORY OF:**

- |                            |                |                    |                |
|----------------------------|----------------|--------------------|----------------|
| Multiple Sclerosis         | Yes ___ No ___ | Pituitary/Hormone  | Yes ___ No ___ |
| Brain Aneurysm             | Yes ___ No ___ | Loss of Hearing    | R ___ L ___    |
| Stroke                     | Yes ___ No ___ | Arm Weakness       | R ___ L ___    |
| Seizures                   | Yes ___ No ___ | Leg Weakness       | R ___ L ___    |
| Trauma                     | Yes ___ No ___ | Loss of Balance    | Yes ___ No ___ |
| Dizziness                  | Yes ___ No ___ | Memory Loss        | Yes ___ No ___ |
| Cerebral Arteriogram       | Yes ___ No ___ | Facial Pain        | Yes ___ No ___ |
| Blurred Vision R ___ L ___ | Yes ___ No ___ | Sinus Trouble      | Yes ___ No ___ |
| High Blood Pressure        | Yes ___ No ___ | Headaches or Fever | Yes ___ No ___ |

If Yes, briefly describe or other (please specify) \_\_\_\_\_

**I acknowledge that all the information given is accurate and thereby consent to have Magnetic Resonance Imaging performed on me.**

**I do not have a pacemaker, brain aneurysm clips or cardiac defibrillator.**

Date: \_\_\_/\_\_\_/\_\_\_

**Patient's Signature**

**Technologist to Complete Below this Line**

Tech: \_\_\_\_\_ Contrast used: \_\_\_\_\_ / \_\_\_\_\_ cc's Lot # \_\_\_\_\_