



NORTH DOVER
R A D I O L O G Y

BRAIN/SKULL MRI/MRA QUESTIONNAIRE

Today's Date: _____

Name _____ DOB _____ AGE _____

What complaints or symptoms lead you to see your doctor? _____

How long have you had these symptoms? _____

Have you ever had trauma or injury to your head or brain? _____ When? _____

If yes, please describe _____

Do you have a history of any of the following? Please check where appropriate.

Stroke	_____	Loss of Hearing	Left _____	Right _____
Heart Attack	_____	Loss of Balance	Left _____	Right _____
TIA	_____	Loss of Vision	Left _____	Right _____
Dizziness	_____	Double Vision	Left _____	Right _____
Eye Deviation	_____			
Memory Loss	_____			
Hallucinations	_____			
Hormonal Imbalance	_____			

Please list any other medical problems that you have, or have had in the past.

Please list any and all medications you are currently taking.

Patient's Signature _____