

Eastern Radiologists, Inc. Greenville MRI Brain Questionnaire

Name: _____ Date: _____

Age: ____ Birth date: __/__/____ Height: ____ Weight: ____ Gender: M F

Are you returning to your referring physician today? Y N Date of return: _____

Briefly describe your condition and how long you have had these symptoms. _____

Do you have a history of cancer, stroke, surgery, radiation or chemotherapy? _____

Please describe: _____

Have you had any of the following performed on your brain? If so, please indicate when, where, and brief results.

TEST	When	Hosp/Imaging Center	Results
CT scan			
MRI scan			
Arteriogram or Doppler			

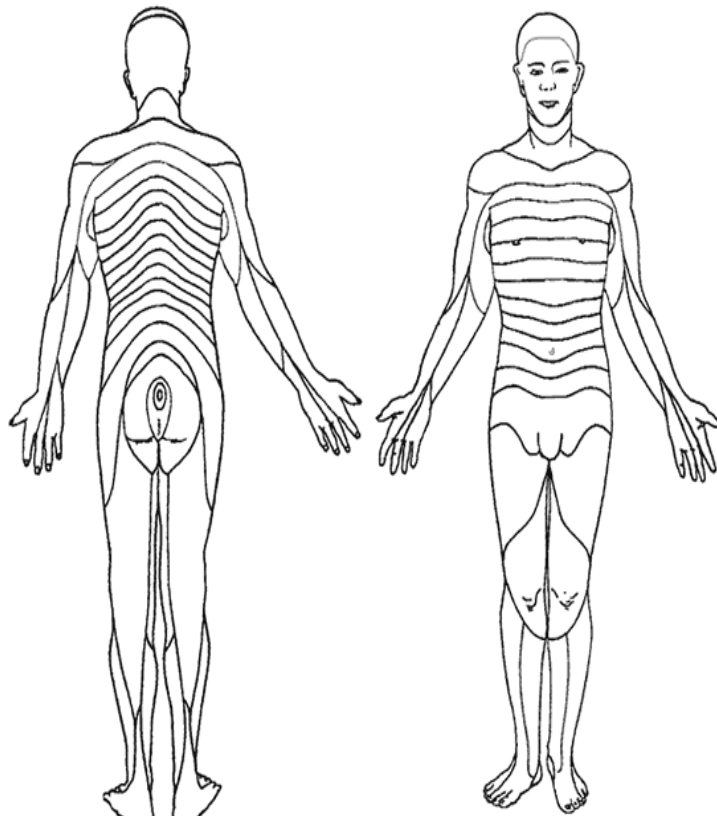
Please shade in areas of pain, weakness or numbness.

LEFT

RIGHT

RIGHT

LEFT



Additional information: