



Head MRI/MRA

Today's Date: _____

Patient Information: _____
(Last Name) (First) (Middle) (Birth Date) (Weight)

Primary symptoms: _____

Have you ever had a head injury? _____ If so, when? _____ Do you have headaches? _____

Difficulty walking? _____ Seizures? _____ Lt or Rt. sided weakness? _____ (Please specify which)

When did symptoms start? _____

Have you had surgery in your brain region? _____ Radiation therapy? _____ Chemotherapy? _____

If yes, please describe your treatment _____

Do you have any other medical conditions that we should know about? _____

Patient Signature: _____ **Date:** _____

(Parent/Guardian required for minor consent)