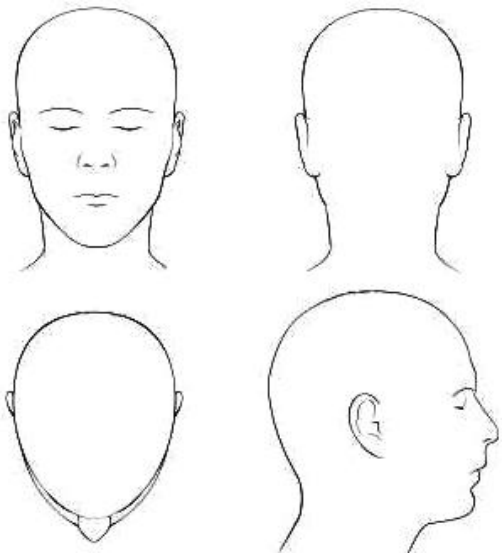
MRI Head/Body/Extremities

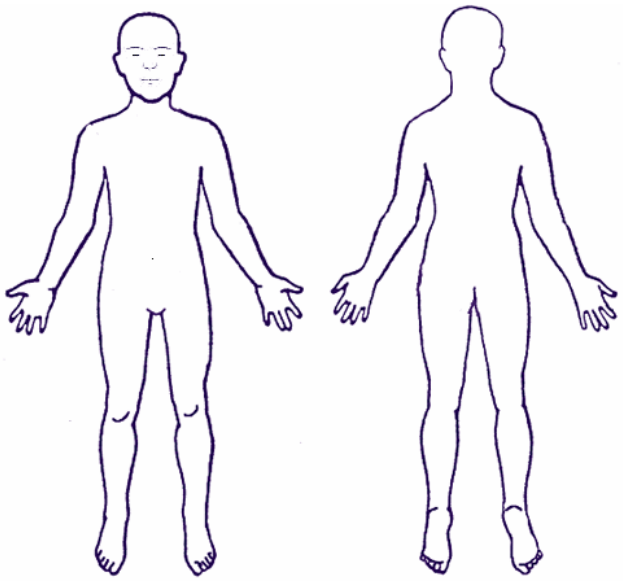
Name		Acct #		Date	
Exam					

	No	Yes	If yes, explain/list when indicated
Do you have pain? Where?			
How frequent is the pain?			
Have you had other tests for this present problem?			
Is this the result of an injury? Describe			Date of Injury:
Did you take any medication for sedation or to relax you today?		☐ No	☐ Yes
If yes, what?			

Please shade in area(s) affected by pain or numbness

☐ Stroke	☐ Head Injury	☐ Dizziness
☐ Fainting	☐ Headaches	☐ Hearing Changes
☐ Visual Changes	☐ Weakness	☐ Nausea/Vomiting





Date _____Patient Signature _____/Signature of patient's representative_____

(Relationship: __ Parent (minor under 18 years) __Court appointed Guardian)

Technician Review & Signature_____

Fax to Premier MRI/CT: 800.792.6950