MedStar Georgetown University Hospital

MedStar Georgetown Radiology
Brain, Neck & Spine MRI Questionnaire

MRN _____

Last Name: _____ First Name: _____ Middle Initial: _____

Sex: ❑ Female ❑ Male Date of Birth: _____/_____/_____ Date of Service: _____ / _____ / _____

Name of Individual Completing this form: _____ Relationship to Patient: _____

Please explain the reason your doctor requested this study:

Did you bring any prior imaging studies from another institution? ❑ YES ❑ NO

If yes, what type? _____

Do you have a history of cancer or tumors? ❑ YES ❑ NO

If yes, what type? _____

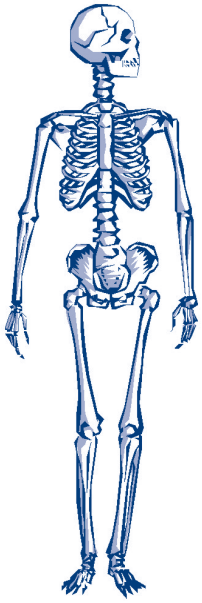
When was the diagnosis made? _____

How was it treated? _____

Have you had prior surgery on the part of the body we are scanning today? ❑ YES ❑ NO

If yes, what type, when and at what institution?

If you are having a spine MRI, please mark areas of pain, numbness or weakness on the diagram below.



R **L**

Does pain radiate down your: ❑ Right arm? ❑ Left arm?

(Check all that apply) ❑ Right leg? ❑ Left leg?