RapidSound, Inc / Green Valley Imaging
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BRAIN MRI EVALUATION FORM

Name: ____
Last First Middle

DOB: _____/_____/_______ Date: _____/_____/_______

1. What was your main complaint when you visited your doctor? ____________________________________

____

2. Do you have headaches? _______ If so, describe:____________________________________
3. Do you have weakness? _______ If so, describe:____________________________________
4. Have you had seizures? _______ If so, what kind:__________________________________
5. Do you have difficulty walking? _______ If so, describe:____________________________________
6. Is your vision normal? _______ If not, describe:____________________________________
7. Did the difficulty come (circle one) Gradually / Suddenly / Days / Weeks / Months / Years
8. Have you had surgery? _______ If so, what kind:__________________________________
9. Have you had difficulty (circle all that apply) Thinking / Remembering / Calculating
10. Do you have difficulty thinking or saying the correct words? _______
11. Have you had difficulty with your balance? _______
12. Describe your health ____
13. Do you have any other medical conditions? ____
14. Are you taking any medications? _______ If so, what kind:__________________________________