MRI Patient Clinical History Head/Neck

Name:_____ Date of Birth:____/____/____

What area of your body is being imaged with MRI today? Brain Orbits Neck Other:_____

Describe the symptoms that you are having in this area:_____

_____

_____

Have you ever had any other imaging of this area?_____

Have you ever had surgery or other procedure in this area?_____

How long have you had these symptoms, and how often do they occur?_____

_____

Are these symptoms related to a prior injury or surgery? If yes, then please describe:_____

_____

Please use the diagram and space below to detail your symptoms