EASTERN RADIOLOGISTS
GREENVILLE MRI

2101 W Arlington Blvd, Suite 110, Greenville, NC 27834
Mon–Fri 7am–9pm • Sat / Sun 8am–8pm
252.752.5000 | easternrad.com

Patient Name ________________________ DOB ___ /___ /___ Date ___ /___ /___ MRN _________

QUESTIONNAIRE: BRAIN

Weight: __________ Height: ________________ Gender: Male Female

Are you returning to your referring physician today? Yes No Date of return: ______________________

Briefly describe your condition and how long you have had these symptoms. ______________________

____

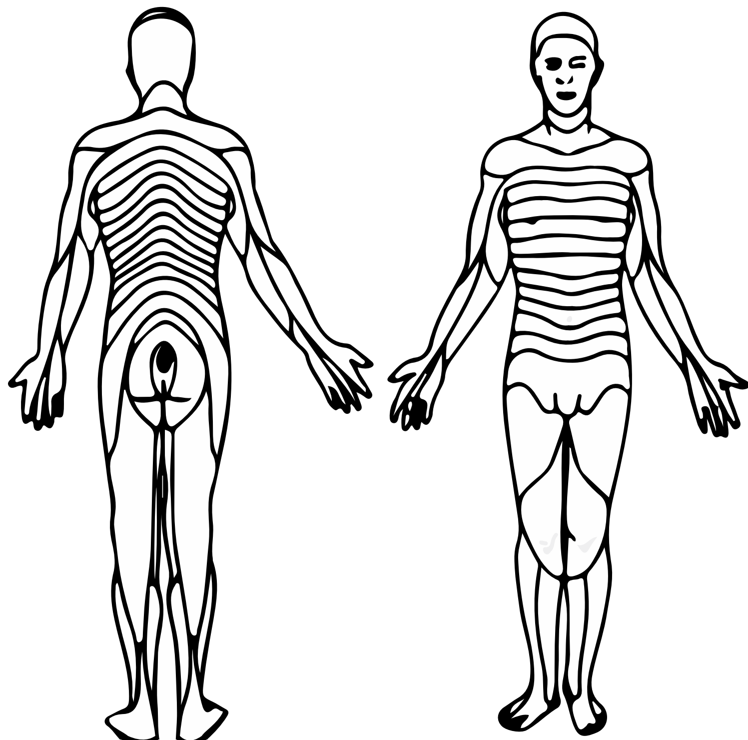
Do you have a history of cancer, stroke, surgery, radiation or chemotherapy? Yes No

Please Describe: ____

Have you had any of the following performed on your brain? If so, please indicate when, where, and brief results.

TEST	When	Hosp/Imaging Center	Results
CT scan			
MRI scan			
Arteriogram or Doppler			

Please shade in areas of pain, weakness or numbness. Left Right Left Right



Additional comments: ____

REV. 3.8.16