

HIGH FIELD OPEN MRI PATIENT QUESTIONNAIRE  
**MRI BRAIN**

Name \_\_\_\_\_ Date \_\_\_\_\_

Do you have a history of cancer? If yes, please detail \_\_\_\_\_  
\_\_\_\_\_

What complaints or symptoms led you to seek medical help? \_\_\_\_\_  
\_\_\_\_\_

For each symptom **CIRCLED** below, please give details:

History of trauma

Sinusitis

Fever

Nausea

Dizziness

Seizures

Vomiting

Memory loss

Speech difficulty

Headaches

Eye muscle weakness

Hearing loss

Numbness/tingling sensation

Cognitive difficulties (ex. Confusion, dementia)

Visual disturbances (double vision, blurred vision)

Facial irritation/pain

Motor function disturbances (weakness, sensory changes)

Additional comments or explanations

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