



Lakemont Medical Center, 7499 Old Hwy. 441 South, Lakemont, GA 30552  
Phone: 706-782-0770 Fax: 706-782-1091

MRI BRAIN

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

Age \_\_\_\_\_ Weight \_\_\_\_\_

Please give a brief description of your symptoms related to the area to be scanned:

\_\_\_\_\_

Are you having headaches? Yes \_\_\_ No \_\_\_

If yes, give location, duration, and length of time you have had headache.

\_\_\_\_\_

Have you had any surgeries or any confirmed abnormalities of the brain?

\_\_\_\_\_

Do you have any of the following symptoms?

	Yes	No	Description
Hearing loss	___	___	_____
Tinnitus	___	___	_____
Dizziness (vertigo)	___	___	_____
Weakness	___	___	_____
Stroke	___	___	_____
Vision problems	___	___	_____
History of cancer or tumor	___	___	_____
Loss of function of legs or arms	___	___	_____
Numbness in legs or arms	___	___	_____
Memory loss	___	___	_____
Pituitary gland tumor	___	___	_____
Any other symptoms	___	___	_____

Prior scans (for the area being scanned today):

CT	Yes ___ No ___	When _____	Where _____
MRI	Yes ___ No ___	When _____	Where _____
X-ray	Yes ___ No ___	When _____	Where _____
Nuc medicine	Yes ___ No ___	When _____	Where _____

Technologist: \_\_\_\_\_