NORTHERN BERKSHIRE IMAGING CENTER
MRI NEUROLOGICAL PATIENT INFORMATION FORM

Patient Name:________________________________ **Date of Birth:**________________

Have you ever had any type of surgery? Please give dates if possible.

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Have you had any previous examinations of any kind pertaining to your exam today?
Give date and location if possible.

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____

Do you have any numbness or weakness? **Yes**_______ **No** _______
Describe: ____

Have you had any bowel or bladder changes? **Yes**_____ **No**_____
Describe:____

Do you have a history of any of the following:
Diabetes_____Stroke_____Seizures_____ Multiple Sclerosis_____
Cancer_____ (Type________________ Radiation Treatment? Y_____N______)

Do you have a history of dizziness or loss of balance? Describe.

____

Any injury to the area being examined? Yes_____No______
Describe:____

Do you have any other medical conditions? Describe:

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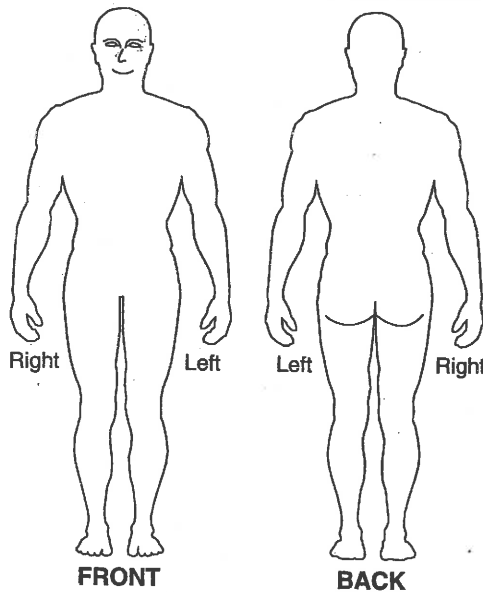
____

Please shade in the areas of your problems below.



Signature:____ Date: ____________________