



Marietta Imaging Center

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Patient Evaluation Form: Name _____

BRAIN EXAM:

Have you ever had brain surgery and when? Y N _____

Do you have any history of cancer? Y N _____

Describe _____

Are you having any headaches? Y N _____

Describe _____

Are you having any weakness? Y N Where? _____

When? _____

Are you having any seizures? Y N _____

Describe _____

Do you have difficulty walking? Y N Describe _____

Do you have visual changes? Y N Describe _____

Did your problems come on Gradually - Over Years - Months - Weeks - Days - Suddenly (circle one)

SPINE EXAM:

Have you ever had spinal surgery and when? Y N _____

Do you have any history of cancer? Y N Describe _____

Are you having pain? _____

Does the pain go down your Arm - Leg - Front - Back - Into Hand - Into Foot - (Circle any)

Are you having weakness? Y N Where? Which _____

Side? _____

Do you have difficulty walking? Y N _____

Describe _____

Did your problems come on Gradually - Over Years - Months - Weeks - Days - Suddenly (circle one)

Have you had any previous spine injuries? Y N _____

Describe _____

ALL OTHER AREAS :

Have you ever had surgery to this area and when? Y N _____

Do you have a history of cancer? Y N Describe _____

Are you having pain? Y N Location Front - Back - Right Side - Left Side - (circle any)

Is there a mass? Y N Describe _____

Are you having weakness? Y N Describe _____

Have you ever dislocated or broken this area? Y N What was done? _____

Did your problems come on Gradually - Over Years - Months - Weeks - Days - Suddenly (circle one)

Was this problem from an injury? Y N Describe _____

PREVIOUS MRI:

Have you ever had an MRI of the area we are scanning today? Y N _____

Where was that scan done? _____

When was that scan done? _____