In order to help us plan and interpret your examination, please fill out this questionnaire completely.

Name__________________________________________ Sex____

Previous CT or MRI examination of the brain/spine: Yes____ No____
If Yes to the above question, when? __________
Where: William Beaumont Troy_____ Royal Oak_____ Other hospital_________

Have you noted any of the following: (Note: If the answers are yes to any questions below, please indicate right or left in the appropriate box).

Change in Memory Yes____ No____
Change in Behavior Yes____ No____
Headache Yes____ No____
Fainting Spells Yes____ No____
Change in Vision Yes____ No____
Double Vision Yes____ No____
Difficulty with handwriting Yes____ No____
Dizziness Yes____ No____
Buzzing in Ears Yes____ No____ Right____ Left____
Loss of Hearing Yes____ No____ Right____ Left____
Sense of Falling Yes____ No____ Right____ Left____
Weakness in Arms Yes____ No____ Right____ Left____
Weakness in Legs Yes____ No____ Right____ Left____
Numbness in Arms Yes____ No____ Right____ Left____
Numbness in Legs Yes____ No____ Right____ Left____
Numbness in Face Yes____ No____ Right____ Left____

Have you ever had a Stroke? Yes____ No____ If YES, when _____________________
Have you had Seizures? Yes____ No____ If YES, for how long_______________
Have you had a serious head injury? Yes____ No____ If YES, when_______________
Have you had any operation to your head, face or sinuses? Yes____ No____ If YES, when_______________

Do you have a diagnosis of cancer or tumor? Yes____ No____

If YES, what type of tumor and where was the tumor found? _____________________
MRI EXAM OF THE SPINE (CERVICAL, THORACIC, LUMBOSACRAL)

In order to help us plan and interpret your examination, please fill out this questionnaire completely.

Name____________________________________________________       Sex________

Previous CT or MRI examination of the spine: Yes_____ No_____

If Yes to the above question, when? ______________________

Where: William Beaumont Troy_____ Royal Oak_____ Other hospital_________

Do you have any of the following symptoms? If you respond YES, indicate the site and/or side.

**Pain**
- Neck Yes____ No____
- Upper Back Yes____ No____
- Lower Back Yes____ No____
- Upper Extremity Yes____ No____ Right____ Left____
- Lower Extremity Yes____ No____ Right____ Left____

**Tingling Sensation**
- Upper Extremity Yes____ No____ Right____ Left____
- Lower Extremity Yes____ No____ Right____ Left____

**Weakness**
- Upper Extremity Yes____ No____ Right____ Left____
- Lower Extremity Yes____ No____ Right____ Left____

**Numbness**
- Upper Extremity Yes____ No____ Right____ Left____
- Lower Extremity Yes____ No____ Right____ Left____

Have you had spinal surgery?       Yes____ No____

If YES, to the above, which area: Cervical spine____ Thoracic spine____ Lumbosacral spine____.

If known, what vertebral segment did you have surgery at? _______________________________________

Do you have a diagnosis of cancer or tumor? Yes____ No____

If YES, what is the primary site or diagnosis? _________________________________________________

Using the figures, please shade in the areas affected by pain and/or numbness. Please be precise.
MRI EXAMINATION OF THE NECK

In order to help us plan and interpret your examination, please fill out the questionnaire completely.

Name____________________________________________________       Sex________

Previous CT or MRI examination of the spine: Yes_____ No_____  
If Yes to the above question, when? _________________  
Where: William Beaumont Troy_____ Royal Oak_____ Other hospital_________

Are you able to feel a mass or lump? Yes____ No____
If yes, please mark the site of the lump on the diagram below.

If you have a mass or lump, is it painful? Yes____ No____
Do you have difficulty or pain swallowing? Yes____ No____

Have you had a recent history of: (Check all that apply)
  Cold or Flu____
  Fever____

Do you have any of these symptoms (Check all that apply)
  Sinus Congestion _____
  Nose Bleed _____
  Double Vision _____
  Loss of weight _____
  Loss of appetite _____
  Facial pain _____
  Facial numbness _____
  Facial swelling _____
  Ear ache _____
  Buzzing in ears _____
  Loss of hearing _____

Do you have a diagnosis of cancer or tumor? Yes____ No____
If YES, What is the primary site or diagnosis? ____________________________________________

Have you ever had surgery to you neck, head, or sinuses? Yes____ No____
If YES, Where (Sinuses, tongue, neck, jaw, etc…) ____________________________

Have you had or are you having chemotherapy? Yes____ No____
Have you had or are you having radiation-therapy? Yes____ No____
Have you had radiation-seed implant? Yes____ No____

Do you smoke, or have you ever smoked? Yes____ No____

Describe any additional problems, complaints or information. ____________________________________________

Please Shade area of Abnormality on Diagram below:

[Diagram of head with right and left sections labeled with shaded areas]