THE BRAIN TUMOR FOUNDATION
ROAD TO EARLY DETECTION

MRI SCREENING MEDICAL HISTORY FORM

MRN: _____

Name: _____ **Date of Procedure:** _____
(Last, First, MI)
_____

Address: _____
_____
_____

EMAIL:_____

Phone: _____**Cell Phone:**_____

DOB: ___/___/_____ **Gender:** __Male __ Female

Place of Birth: _____ **Occupation:** _____

Country of Origin _____

Race/Ethnicity:

__ White
__ Black or African American
__ American Indian or Alaska Native
__ Native Hawaiian or Other Pacific Islander
__ Asian
___ Chinese ___ Japanese
___Korean ___ Other _____
__ Hispanic or Latino
___ Puerto Rican ___ Dominican
___ Mexican ___ Cuban
___ Latin American ___ Other _____

Medications: _____
_____

Medical History: ___ **Stroke** When?_____ ___ **Hypertension**
___ **Epilepsy** ___ **Cancer** type _____
___ **Other** _____

Symptoms (check all that apply)**:** __ Headache __ Seizures __Memory Loss
__ Weakness __ Nausea __ Vomiting
__ Vision Changes __ Numbness or Tingling
__ Personality Change ___Loss of Coordination

Cell Phone Use:

Most Frequently Used Brand: _____

For how many years have you used a cell phone? _____

Which Ear Do You Use Primarily? ___ Right ___ Left ___ Both

Family History:

	Gender	Alive or Deceased?	Age at Death or Currently	History of Brain Tumor?	Type of Brain Tumor
Mother				**N Y**	
Father				**N Y**	
Sibling 1	**M F**			**N Y**	
Sibling 2	**M F**			**N Y**	
Sibling 3	**M F**			**N Y**	
Sibling 4	**M F**			**N Y**	

	Gender	History of Brain Tumor?	History of Other Cancer?	Type of Other Cancer
Mother		**N Y**	**N Y**	
Father		**N Y**	**N Y**	
Sibling 1	**M F**	**N Y**	**N Y**	
Sibling 2	**M F**	**N Y**	**N Y**	
Sibling 3	**M F**	**N Y**	**N Y**	
Sibling 4	**M F**	**N Y**	**N Y**	

Must Complete: Send results to: _____
Doctor's Name

Address: _____
_____
_____

Email Address _____
Phone Number: _____

Fax Number: _____