CT Questionnaire – **Brain/Head**

Name: _____ D.OB.___/___/___ Age: ____ Sex: M/F
(Last) (First)

WT: ____ HT:__ft. __in. Referring Physician: _____

- Please provide a summary of your symptoms specific to your exam today:_____
  _____
- The symptoms primarily involve what part of your body? _____
  If applicable, please circle: RIGHT or LEFT or BOTH sides of your body
- Did this symptom/condition arise suddenly? Yes___ No___ When did the problem start?_____
- How long have you been treated for this problem?_____ Circle if problem is **Chronic** or **Acute** or **Temporary**
- Is this your initial visit or follow-up visit?_____
- What is/was the cause of the problem? Accident / Motor Vehicle / Fall / Work-Related Injury (Complete Injury Form)
- Do you experience headaches? Yes___ No___
  If yes, which type: Cluster - Vascular – Tension - Post Trauma - Drug induced – Exertion
  Migraine: Variant – Recent – Intractable
- Are you having pain? Yes___ No___ If Yes circle if pain is severe / moderate / mild
  If Yes, circle if pain is generalized or localized. If localized pain, describe specific area of pain_____
- Do you have any of the following: swelling / bruising / inflammation / contusion / sprain / open wound (please circle)
- Did any existing disease/condition attribute to this current symptom? _____
- Do you have a history of being diagnosed with cancer? Yes ___ N0___ When?_____ Type?_____
- Have you been treated with either Radiation or Chemotherapy? (If yes, circle) Date started_____ Completed_____
- Any surgery on area being imaged? Yes___ No___ If yes, when and what type?_____
- Any other medical or family history pertaining to your exam being performed today?_____
  _____

DO YOU HAVE ANY HISTORY OF?

• Brain Aneurysm	Yes___ No___	Loss of Hearing	R__ L__	Facial Pain	Yes___ No___
• Stroke	Yes___ No___	Arm Weakness	R__ L__	Blurred Vision	Yes___ No___
• Seizures	Yes___ No___	Leg Weakness	R__ L__	Sinus Trouble	Yes___ No___
• Trauma	Yes___ No___	Loss of Balance	Yes___ No___	Fever	Yes___ No___
• Dizziness	Yes___ No___	Memory Loss	Yes___ No___	High Blood Pressure	Yes___ No___
• Headaches	Yes___ No___	Cerebral Arteriogram	Yes___ No___	Shunt	Yes___ No___

- Do you have any known allergies?:_____
- Are you pregnant or possibly pregnant? Yes___ No___ Date of last menstrual period_____
- Prior Diagnostic Imaging of Head/Brain? Yes___ No___ If yes, Date/Study/Facility_____
  _____

I acknowledge that all the information given is accurate and thereby consent to have CT with or without an injection of contrast performed on me.

Patient's signature: _____ Date: ___/___/___Technologist Initials: _____