BRAIN CT QUESTIONNAIRE - Patient Information Form

NAME____DATE_______________________

1. Why are you having a CT Exam?____
____

2. How long have these symptoms been present?__________________________________

3. Which hand do you write with? RIGHT LEFT (please circle)

4. Have you noted any of the following? (Note: If the answer is yes to any question which has right or left under them, please circle the appropriate answer).

	YES	NO		YES	NO
Change in memory	☐	☐	Difficulty breathing	☐	☐
Fainting spells	☐	☐	Buzzing in ears right left	☐	☐
Headache	☐	☐	Difficulty with speech	☐	☐
Double vision	☐	☐	Weakness in arms right left	☐	☐
Loss of hearing right left	☐	☐	Dizziness	☐	☐
Change in vision	☐	☐	Weakness in legs right left	☐	☐
Sense of falling to right to left	☐	☐	Numbness to face right left	☐	☐
Numbness to arms right left	☐	☐	Numbness to legs right left	☐	☐

Weakness of one-half of the body? ☐ No ☐ Yes If yes, which half? ☐ Right ☐ Left

5. Do you have, or have you ever had, cancer?______If so, what is the primary site?____________________
☐ Chemotherapy? ☐ Radiation?

6. Are you a diabetic?_______If yes, is your diabetes controlled by insulin/diet/medicine?________________

7. Do you have high blood pressure?_______Do you take medication for it?__________________________

8. Do you have allergies to food/medicine or iodine or IV Dye? If so, what?_________________________

9. Do you have asthma or hayfever?____

10. Do you have any heart problems (shortness of breath, rapid or irregular heart rate, chest pain)?____________

11. Have you been on antibiotics in the last 2 weeks?__________________________________

12. Female Patients: Date of last menses________________ Any chance you could be pregnant? ☐ Yes ☐ No

13. List any medications you are taking now____
____

14. Do you have a history of stroke, seizures, serious head injury or any operations on your head?
If so, list:____

15. Have you noticed a change in your behavior?__________________________________

Signature:____Date: ____________________

CT EXAM QUESTIONNAIRE
Patient Information Form

NAME____DOCTOR:__________________DATE_______________

GENDER: ☐ Male ☐ Female Age: _____________

1. Why are you having a CT exam today?____

   ____

2. How long have your symptoms been present?____

3. Have you ever had a CT examination?____

   If yes A: Where? (hospital, etc)____

   B: What part of the body____

4. Have you ever had any of the following examinations?

   Exam **Where** **When**

   Nuclear____

   Ultrasound____

   UGI or Barium Enema____

   IVP or Cystoscopy____

   Chest X-Rays____

5. Do you have, or have you ever had, cancer?______If so, what is the primary site?_____________________
   ☐ Chemotherapy? ☐ Radiation?

6. Are you a diabetic?_______If yes, is your diabetes controlled by insulin/diet/medicine?________________

7. Do you have high blood pressure?_______Do you take medication for it?___________________________

8. Do you have allergies to food/medicine or iodine or IV Dye? If so, what?___________________________

9. Do you have asthma or hayfever?____

10. Do you have any heart problems (shortness of breath, rapid or irregular heart rate, chest pain)?_________

11. Have you been on antibiotics in the last 2 weeks?____

12. Female Patients: Date of last menses_____________ Any chance you could be pregnant? ☐ Yes ☐ No

13. List any medications you are taking now____

    ____

14. Have you had any operations (especially on the abdomen, neck or groin)? If yes, where?______________

    ____

Signature:____Date:___________________________