Distinguished Diagnostic Imaging P.C.

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Board Certified Radiologist

MRI • BONE DENSITOMETRY • X-RAY • ULTRASOUND • MAMMOGRAPHY • CT SCAN

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CT Evaluation Questionnaire
Brain Evaluation

Patient's Name _____ Date _____

DDI Account # _____

1.	What was your chief complaint when you visited your doctor?					
2.	What do you think caused your problem?					
3.	When did your symptoms begin?					
	Days _____ Weeks _____ Months _____ Years _____					
4.	Describe your problem:	No	Yes	Which side?		
				Left	Right	Both
a.	Do you have any headaches?					
b.	Do you have any problem with you balance?					
c.	Do you have any dizziness?					
d.	Do you have any weakness?					
e.	Do you have any seizures?					
f.	Do you have any hearing loss?					
g.	Do you have any ringing in the ear?					
h.	Do you have any difficulty walking?					
i.	Do you have any vision problem?					
j.	Do you have any memory problem?					
5.	Do you have any history of: ___ Brain tumor ___ Stroke ___ Epilepsy ___ Cancer ___ Aneurysm					
6.	Do you have any other medical condition we should know about? If yes, explain.					

Please continue to fill out questions on the back of this form.

7.	Have you ever had chemotherapy, radiation or Gamma Knife?___ No__ Yes If yes, when and why?
	Date of last therapy ____-____-____ Date of next therapy ___-___-___
8.	Have you had previous studies of your brain? No ___ Yes___ ____ CT ____ MRI ____ X-RAY If yes, where? _____ Date ___-___-___

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Patient's History:	
Techs. Notes:	
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