<u>BRAIN IMAGING</u>

Patient Name_______________________DOB_____-_____-____Weight___Height___
Address____SS#______-______-______
Phone_____-_____-_____ Cell_____-_____-______ Work _____-_____-_____

Please check the appropriate response

Did you have an injury to your head Yes No if yes, when ______________

Have you ever had head or brain surgery Yes No
If yes what type of surgery and when____
____

Do you have a history of any illness?(MS, Seizures, Diabetes, Stroke, Hypertension, etc…) Yes No if yes, please describe___________________________________
____

Any prior studies of your head or brain(CAT Scan, X-rays, etc…)? Yes No
If yes, what type of study and location____
____

Do you experience headaches?	Yes	No	RT	LT
Do you experience dizziness?	Yes	No	RT	LT
Do you experience hearing loss?	Yes	No	RT	LT
Do you experience ringing in your ears?	Yes	No	RT	LT
Do you experience blurred or double vision?	Yes	No	RT	LT

Please explain the location of pain and/or chief complaint_________________________
____
____
____

__________________________________ ________________________ ____/____/____
Signature of person completing form Relationship to patient Date