MIDDLETOWN
MEDICAL IMAGING

***BRAIN/SKULL CT/MR QUESTIONNAIRE***

***Today's Date:***_____

Name_____DOB_____AGE_____

What complaints or symptoms lead you to see your doctor?_____

_____

How long have you had these symptoms?_____

Have you ever had trauma or injury to your head or brain?_____When?_____

If yes, please describe_____

Do you have a history of any of the following? Please check where appropriate.

| | | | | |
|---|---|---|---|---|
| Stroke | _____ | Loss of Hearing | Left____ | Right____ |
| Heart Attack | _____ | Loss of Balance | Left____ | Right____ |
| TIA | _____ | Loss of Vision | Left____ | Right____ |
| Dizziness | _____ | Double Vision | Left____ | Right____ |
| Eye Deviation | _____ | | | |
| Memory Loss | _____ | | | |
| Hallucinations | _____ | | | |
| Hormonal Imbalance | _____ | | | |

Please list any other medical problems that you have, or have had in the past.

_____

_____

_____

Please list any and all medications you are currently taking.

_____

_____

_____

Patient's Signature_____