CT HEAD/BRAIN QUESTIONNAIRE

NAME: _____ DOB:_____

Females: LMP?_____ Are you Pregnant? Y /N

Have you had any brain/head surgery? Y / N: If yes, when? _____
What facility? _____

Do you know what kind? Y / N: If yes, explain:
_____

Have you had prior exams relevant to this visit? Y /N If yes,
where and when? _____

Symptoms
Headache _____Acute _____Chronic
Frequency/Duration_____

For each symptom checked below please describe:
_____ History of trauma_____
_____ Fever_____
_____ Sinusitis_____
_____ Nausea_____
_____ Dizziness_____
_____ Vomiting_____
_____ Seizures_____
_____ Eye muscle weakness_____
_____ Hearing Loss_____
_____ Numbness/ Tingling sensation_____
_____ Cognitive difficulties_____
_____ Visual disturbance (blurred, double) _____
_____ Facial irritation_____
_____ Motor Function disturbance (weakness, sensory changes) _____

How long have you had the above symptoms?_____

History on patient only:
_____ History of medical disease (Parkinson's, Arthritis) _____

_____ History of Cancer (please indicate primary cancer) _____