WOODBRIDGE RADIOLOGY

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_____