

CT / MRI OF THE BRAIN

PATIENT NAME: _____

REFERRING PHYSICIAN: _____

REASON FOR EXAMINATION: _____

DO YOU CURRENTLY OR HAVE YOU HAD ANY OF THE FOLLOWING SYMPTOMS?

_____ GENERALIZED WEAKNESS AND FATIGUE

_____ FEVER

_____ DIPLOPIA

_____ DIZZINESS

_____ ABNORMAL FACIAL MOVEMENT OR FACIAL SENSATION

_____ VISUAL DIFFICULTY (PROBLEMS SEEING)

_____ SEIZURE ACTIVITY

_____ MULTIPLE SCLEROSIS

_____ HEARING DIFFICULTIES

_____ UPPER EXTREMITY OR LOWER EXTREMITY WEAKNESS

_____ DIFFICULTY WITH BALANCE

_____ ANY HISTORY OF CANCER

IF YES, TYPE OF CANCER _____