DMI Dynamic Medical Imaging

Stand-up MRI
CT
Ultrasound
X-Ray

BRAIN/SKULL CT/MR QUESTIONNAIRE

Today's Date: ____________________

Name ______________________________ DOB ________________ AGE ___________

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

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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.

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Please list any and all medications you are currently taking.

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Patient's Signature ____