Hackensack Radiology Group / New Century Imaging

BRAIN EVALUATION

THESE QUESTIONS APPLY ONLY TO THE AREA BEING SCANNED TODAY

Last Name	First Name	Middle	Today's Date

Age	Height	Weight

1. Describe what made you go see your doctor: _____

   _____

2. Do you have headaches? Yes ❑ No ❑

3. Headaches where (ie: front/back of head)? _____

   _____

4. Have you had seizures or other CNS deficit (stroke, fainting, etc.)? Yes ❑ No ❑

5. Have you had any changes in vision, speech, balance, or thinking? Yes ❑ No ❑

6. Describe changes: _____

   _____

7. Have you had surgery <u>on this area</u>? Yes ❑ No ❑

8. If yes, what surgery and when? _____

   _____

9. Have you had prior imaging of this area? Yes ❑ No ❑

10. When and where? _____

11. Do you have a <u>personal</u> history of cancer? Yes ❑ No ❑ Type _____

12. Do you have any other medical conditions? _____

    _____