SDMI STEINBERG DIAGNOSTIC

History Questionnaire
Advanced Head Imaging

Patient Information Patient Number _____ *to be filled in by tech*

First Name _____ Last Name _____ Age _____

Reason for your Exam *(please describe in detail)*

_____

_____

_____

TECH NOTES: *(for internal use only)*

Contrast _____

Sedation _____

Notes _____

Head *(Circle all that Apply)*

Stroke Memory Loss Tremor Dizziness
Seizures MS Hemorrhage
Headaches *(circle one)*
Acute Chronic Severe Due to Trauma

Migraines *(circle one)* Acute Chronic
Vision Loss *(circle one)* Right Left Both
Hearing Loss *(circle one)* Right Left Both
Numbness/Tingling Where _____
History of head trauma? YES NO
Have you ever been diagnosed with Diabetes?
YES NO
Have you ever had Renal Failure / Dialysis?
YES when:_____ NO

Sinus *(circle all that apply)*

Sinus Infections Headaches Facial Pain
Congestion Runny Nose Frequent Colds
Sore Throats Toothaches Chronic Cough
Post Nasal Drip Nose Bleeds Deviated Nasal Septum
Nasal Polyps Snoring Sleep Apnea
Previous Nasal Fracture

Please list any other related symptoms

_____

_____

Previous sinus surgery? YES NO
If yes, procedure description and date:

_____

_____

Is your problem related to an injury? NO _____ YES _____ *(if yes continue)*

Date of Injury _____ How were you injured *(circle one)* Car Accident Work Other

Describe Injury *(please be specific)* _____

_____

Have you ever been diagnosed with cancer? NO _____ YES _____ *(if yes continue)*

What type of cancer _____ Location _____ Date Diagnosed _____

Current Status *(please circle one)* Newly Diagnosed Recurrence Remission

Treatment *(please circle all that apply)* Surgery Radiation ChemoTherapy

Date of last Treatment _____

Has it spread? NO _____ YES _____ If Yes, Where _____

Is your visit today related to this cancer diagnosis NO _____ YES _____

Previous surgeries related to the affected area you are being seen for today. *(Please list specifically, what and when. Use back if extra space needed.)*

Procedure Description	Date

Previous imaging studies related to the affected area you are being seen for today. *(Please list specifically, what and when. Use back if extra space needed.)*

Procedure Description	Date