C.T.REQUEST: HEAD

☐BRANDYWINE
☐OMEGA IMAGING
☐PIKE CREEK
☐GLASGOW

Patient#: _____ Date: _____

Name of Patient: _____ Age: ____ Date of Birth: __/__/__

Requesting Doctor: _____ Family Doctor: _____

Why do you need this test?: _____

POSSIBILITY OF BEING PREGNANT: ☐ NO, ☐ YES, Date of last menstruation:_____

CLINICAL INFORMATION:

Check if Yes		Side: Left	Side: Right
☐ Seizures	Paralysis	☐	☐
☐ Headache	Weakness	☐	☐
☐ Dizziness	Numbness	☐	☐
☐ Fainting Spell	Hearing Loss	☐	☐
☐ Speech Difficulty	Loss of Vision	☐	☐
☐ Memory Loss			

ALLERGIES:	__Yes,__No
Type: _____	
Heart Problems	__Yes,__No
Kidney Problems	__Yes,__No
Asthma	__Yes,__No
Allergy to x-ray dye	__Yes,__No
Taking glucophage	__Yes,__No
Diabetic	__Yes,__No

Past History: (give details if known)

Head injury : No____, Yes____ , date: _____
Place: _____

Previous brain or sinus Surgery:
No____, Yes____ , date: _____
Stroke:_____ date: _____
Which side of your body: _____

ADDITIONAL PERTINENT INFORMATION:
_____
_____
_____

Any Known Tumor? ☐ No , ☐ Yes : What part of the body: _____ Did you have Radiation: ☐Yes , ☐ No
Any other Surgery? ☐No , ☐ Yes : What part of the body: _____ or Chemotherapy: ☐Yes , ☐ No

PREVIOUS EXAMINATIONS : (give dates and places if known)

	Check if YES:	Date:	Where?
MRI of Head	☐	/ /	_____
C.T. of Head	☐	/ /	_____
Skull X-rays	☐	/ /	_____
Cerebral arteriogram	☐	/ /	_____
Nuclear Medicine Brain Scan	☐	/ /	_____
E.E.G.	☐	/ /	_____
Others, specify:	☐		

Technologist: _____,R.T.