

BRAIN Imaging Evaluation Form

The following information is necessary to comply with the federally mandated ICD-10 billing requirements, which takes effective Oct. 1st 2015.

NAME: _____ **Age:** _____ **Weight:** _____ **Date:** _____

1. What was your chief complaint when you visited your doctor? _____

2. Are you currently experiencing any of these symptoms?

- Headaches _____
Weakness _____
Fainting _____
Weak arms _____ Right / Left
Weak legs _____ Right / Left
Tremors _____
Dizziness _____
Problems Walking _____
Double Vision _____
Blurred Vision _____
Decreased Hearing _____ Right / Left
Numbness or Tingling _____ If yes, **where specifically?** _____
Seizures _____
Trouble Speaking _____
Trouble Swallowing _____
Confusion _____
Thinking/Behavior Problems _____

3. Do you have **ANY** history of **cancer**? If yes, please list:

- a. Type(s) of cancer: _____
b. Diagnosis date(s): _____
c. Treatments you have completed for it (radiation, chemotherapy): _____

4. Have you recently or previously had any of the following?

If you answer yes to any of these, please provide specific details:

Trauma/injury involving the head (please be specific) **YES** or **NO**

Date of Injury: _____ **Where did this occur** (location)? _____

5. Brain Surgery? **YES** or **NO**

6. Brain Bleeding? **YES** or **NO**

7. Any personal history of a Stroke? **YES** or **NO**

8. Brain Cancer? **YES** or **NO**

9. Radiation therapy and/or chemotherapy to the brain specifically? **YES** or **NO**

10. Previous Brain CT scan? _____ When & Where? _____

*How many CT scans (of **ANY** body part) have you had in the last **12 months**? _____

11. Previous Brain MRI scan? _____ When & Where? _____

Female Patients Only: Are you pregnant? _____ *If yes, please notify the technologist immediately!*