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Radiology Associates
of the Fox Valley
333 N. Commercial Street, Neenah, WI

Patient Information Form (PIF) for CN VIII symptoms

Lesions of CN VIII, the associated end organs, and the associated neural pathways in the brain may cause dizziness, vertigo, tinnitus, and hearing loss. In patients with isolated conductive hearing loss, if imaging is indicated, the study of choice is usually a temporal bone CT, in which case the "Temporal Bone/IACs" worksheet should be used. In patients with other symptoms (either alone or in combination), if imaging is indicated, the study of choice is usually a brain MR without and with contrast, with routine brain sequences supplemented by thin slices centered at the porus acusticus. In this case, the "Brain" worksheet is used.

Patient Name: ______________________________ Previous exam: _____________
Date of birth: ______________________________ Patient pregnant: YES NO
Medical Record #: __________________________ Patient breastfeeding: YES NO

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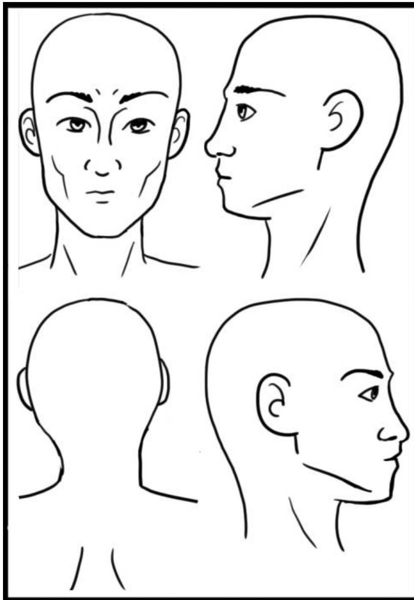
TEMPORAL BONE/IACS

Please mark the location of any pain:



How long have you had your symptoms?	
Have you had prior surgery done on your head/brain? If so, please tell us the approximate date(s) and procedure(s):	
Please check if you have any of the following:	
	Exposure to loud noise
	Stroke
	Hypertension.
	Brain tumor. If so, what kind?
	Fever

If your pain was caused by trauma/injury, please describe how you were injured:

HEARING LOSS AND EAR SYMPTOMS:

	LEFT EAR		RIGHT EAR
	Sudden onset hearing loss		Sudden onset hearing loss
	Gradual onset hearing loss		Gradual onset hearing loss
	Ringing		Ringing
	Drainage		Drainage
	Pain		Pain

Have you ever been diagnosed with cancer? YES NO

If yes, what type? __________________

FOR TECHNOLOGIST USE ONLY

Call result?	No Yes	If "Yes", provider name/number:
Known follow-up appointment?	No Yes	If "Yes" indicate date/time and provider:
	For CT and MR studies	
Was IV contrast injected?	No Yes	If "Yes": ________ mL of _____________ (contrast type)
Hydration protocol?	No Yes	If "Yes", provide details:
Patient premedicated for contrast?	No Yes	If "Yes", provide details:
Abnormal response to contrast?	No Yes	If "Yes", provide details:

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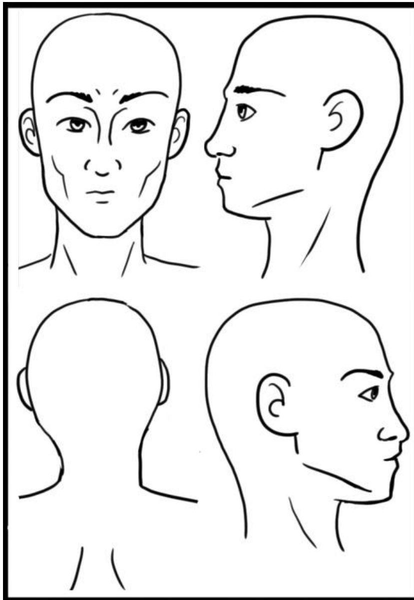
Patient Name: ______________________________ Previous exam: _____________
Date of birth: ______________________________ Patient pregnant: YES NO
Medical Record #: __________________________ Patient breastfeeding: YES NO

Brain

Please mark the location of any pain:



How long have you had your symptoms?	
Have you had prior surgery done on your head/brain? If so, please tell us the approximate date(s) and procedure(s):	
Please check if you have any of the following:	
	Nausea and/or vomiting.
	Dizziness.
	Arm weakness or numbness. Circle one: LEFT RIGHT BOTH
	Leg weakness or numbness. Circle one: LEFT RIGHT BOTH
	Blurred vision. Circle one: LEFT RIGHT BOTH
	Ringing in the ears. Circle one: LEFT RIGHT BOTH
	Hearing loss. Circle one: LEFT RIGHT BOTH
	Strokes.
	Brain tumor. If so, what kind?

If your pain was caused by trauma/injury, please describe how you were injured:

Headache patients, please check all that apply (pick one column):

	NEW OR DIFFERENT HEADACHE		RECURRENT/REPEATED HEADACHE
	This is the worst headache I've ever had.		Light or sound makes my headaches worse.
	This is the first headache I've ever had.		My headaches get worse with physical activity
	My neck feels stiff.		My headaches have a throbbing quality.
	I have sinus congestion and/or drainage.		My headaches only involve one side of my head.
	Headache that changes with my posture.		Headache that changes with my posture.

For those with recurrent/repeated headache, how long do your headaches usually last? _________
Have you ever been diagnosed with cancer? YES NO If YES, what type? ________________
Have you ever had brain radiation therapy? YES NO If YES, when? ________________

FOR TECHNOLOGIST USE ONLY (Fluoro time: ____ or NA)

Call result?	No Yes	If "Yes", provider name/number:
Known follow-up appointment?	No Yes	If "Yes" indicate date/time and provider:
For CT and MR studies		
Was IV contrast injected?	No Yes	If "Yes": ________ mL of _____________ (contrast type)
Hydration protocol?	No Yes	If "Yes", provide details:
Patient premedicated for contrast?	No Yes	If "Yes", provide details:
Abnormal response to contrast?	No Yes	If "Yes", provide details: