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

Patient Information Form (PIF) for Brain symptoms

The following patient information forms are used for patients undergoing imaging of the brain. Patients with dementia, dizziness and vertigo, headache, hearing loss, neurologic deficit, seizure, and tinnitus may undergo may undergo radiography, computed tomography (CT), and magnetic resonance imaging MRI).

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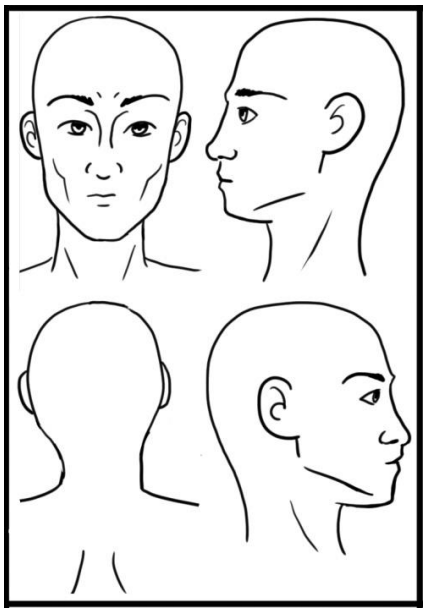
Patient Name: _____ Previous exam: _____
Date of birth: _____ Patient pregnant: YES NO
Medical Record #: _____ Patient breastfeeding: YES NO

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: