RAI PATIENT HISTORY CT BRAIN/FACIAL BONES: **Today's Date:________________________**

Name: _______________________________________Age: _____ Weight: _____ Height:_____Referring Physician:_______________

1. Describe your current problems/symptoms: ____
____Length of symptoms: ___________________

11. If Injury/Accident/MVA –

a. Exact Location (ex. Ear, cheek, scalp, forehead, eye, jaw, nose): ____

b. Type of Injury/Symptoms (Circle One): 1. Abrasion 2. Contusion 3. Laceration/Open Wound 4. Penetrating

5. Foreign Body 6. Swelling 7. Other____

c. Which side of your body? (Circle One): Right Left Bilateral (Right and Left)

2. Any surgery on HEAD/BRAIN: Circle- Y – N - When? ___________________________What was done? ________________________

3. Do you get headaches: Y – N
If yes, circle types of headache: Cluster - Vascular - Tension - Post Trauma – Drug induced - Exertional

4. Do you get migraine headaches: Y – N If yes, circle types of migraines: Migraine variant - Recent migraine - Intractable migraine

Other type of migraine :________________________(if known)

3. Have you been diagnosed with cancer? Circle: Y - N Please provide type and location (ex. Brain, melanoma on left shin; breast cancer, right upper inner quadrant) ____

4. Prior surgery/biopsy related to cancer: Site ___________________________ Facility ______________________________________
Date ____________________

5. Treatments related to cancer:
Chemo – if yes, date of last treatment__________________ provide date of any future treatments planned __________________

Radiation – if yes, date of last treatment__________________ provide date of any future treatments planned ________________

Other treatment – please describe and provide dates: ____

7. Describe any prior or existing medical conditions: (stroke, hypertension, aneurysm, bleed, and diabetes):

____

8. List ALL current medications: ____

9. Do you have any known allergies: ____

11. Prior Diagnostic Imaging: Brain Studies (CT/MRI):

Study/Date/Facility:____

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13. Has your physician prescribed any sedation or medication specifically for this examination? Yes - No
If yes, please indicate drug type and amount____

14. FOR FEMALE PATIENTS:

1. Date of last menstrual period: ___________________________________ Post-menopausal? Yes - No (Circle which apply)
2. Are you pregnant or experiencing a late menstrual period?____________________________ Yes - No

I recognize that if I am pregnant and have radiation to the abdomen/pelvis there is a possibility of injury to the fetus. However, I understand that the likelihood of such injury is slight and that my physician feels that the information to be gained from this exam is important to my health. I, therefore, wish to have this exam performed now.
Signature____ Date: ________________________

I attest that the answers I have provided to the questions on his form are correct to the best of my knowledge.
Patient signature: ____ Date: ___________________

Parent or Guardian signature: ____Relationship: __________ Date: ___________

Technologist signature: ____ Date: ____________________
Comments:____
____
____
____Tech/TechAide initials____________