tollgateradiology.com 401.738.3100

HEAD/BRAIN
CLINICAL QUESTIONNAIRE

NAME: ______________________ DATE: ______________

1. Why has your doctor sent you for this test? Did he/she give you a specific diagnosis?
   ____
   ____
2. Please describe what specific complaints/symptoms have been most bothersome to you?
   ____
   ____
3. How long have you had these complaints/symptoms? ______________
4. Do you have a history of cancer? If so, what type? ______________
5. Are these symptoms the: ☐ same ☐ better ☐ worse
6. Do you have weakness on one side of your body? ☐ yes ☐ no
   If yes, which side? ☐ right ☐ left
7. Have you ever had visual problems? ☐ yes ☐ no
   If yes, please describe: ______________
8. Have you ever had memory problems? ☐ yes ☐ no
   If yes, please describe: ______________
9. Have you ever had hearing problems? ☐ yes ☐ no
   If yes, please describe: ______________
10. Please check if you have any of the following:
    - Balance Problems ☐
    - High Blood Pressure ☐
    - Diabetes ☐
    - Kidney Disease ☐
    - Old Stroke ☐ When: ______________
    - Heart Disease ☐
    - Multiple sclerosis ☐
    - Cancer ☐ Type: ______________
    - Other Medical Problems: ☐ ______________