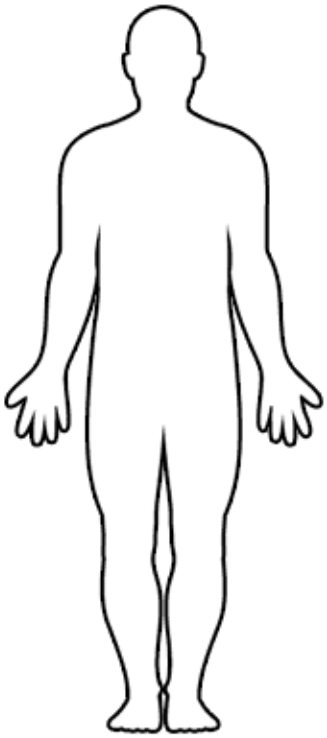
Trinitas Diagnostic Imaging
415 Morris Avenue, Elizabeth, NJ 07208
908-351-7600 (Phone) | 908-351-4406 (Fax)
www.TrinitasDiagnosticImaging.com

Head / Brain / IAC Questionnaire

If you're coming to our center for this test, print this page, fill out the form and bring it in with you on the day of your appointment.



Please circle the portion of your body that is in pain.

FIRST NAME

LAST NAME

AGE WEIGHT DATE

WHAT WAS YOUR CHIEF COMPLAINT WHEN YOU VISITED YOUR DOCTOR?

DO YOU HAVE A HISTORY OF HEADACHES? ☐ YES ☐ NO

IF YES, ON WHAT SIDE? ☐ LEFT ☐ RIGHT ☐ BOTH

DO YOU HAVE A HEARING LOSS? ☐ YES ☐ NO

IF YES, ON WHAT SIDE? ☐ LEFT ☐ RIGHT ☐ BOTH

DO YOU EXPERIENCE DIZZINESS OR NAUSEA? ☐ YES ☐ NO

DO YOU HAVE ANY WEAKNESS OR NUMBNESS IN YOUR ARMS OR LEGS? ☐ YES ☐ NO

IF YES, WHEN DID IT BEGIN ?

IF YES, ON WHAT SIDE? ☐ LEFT ☐ RIGHT ☐ BOTH

HAVE YOU EXPERIENCED ANY VISION LOSS? ☐ YES ☐ NO

IF YES, ON WHAT SIDE? ☐ LEFT ☐ RIGHT ☐ BOTH

ANY LOSS OF CONCIOUSNESS RECENTLY ? ☐ YES ☐ NO

ANY SURGERY IN THE HEAD REGION ?

☐ YES ☐ NO

IF YES, WHEN?

IF YES, WHAT WAS DONE?

ANY HISTORY OF CANCER? ☐ YES ☐ NO

DESCRIBE ANY OTHER MEDICAL CONDITIONS:

DESCRIBE YOUR GENERAL HEALTH:

DESCRIBE ANY FOOD OR MEDICINE ALLERGIES: