TRI-CITY RADIOLOGY

BRAIN Imaging Evaluation Form

The following information is necessary to comply with the federally mandated ICD-10 billing requirements, which takes effective Oct. 1st 2015.

NAME:_____ **Age:**_____ **Weight:**_____ **Date:** _____

1. What was your chief complaint when you visited your doctor? _____
_____

2. Are you currently experiencing any of these symptoms?

Headaches _____
Weakness _____
Fainting _____
Weak arms _____ Right / Left
Weak legs _____ Right / Left
Tremors _____
Dizziness _____
Problems Walking _____
Double Vision _____
Blurred Vision _____
Decreased Hearing _____ Right / Left
Numbness or Tingling _____ If yes, **where specifically**? _____
Seizures _____
Trouble Speaking _____
Trouble Swallowing _____
Confusion _____
Problems with Thinking or Behavior _____

3. Do you have **ANY** history of **cancer**? If yes, please list:
   a. Type(s) of cancer: _____
   b. Diagnosis date(s): _____
   c. Treatments you have completed for it (radiation, chemotherapy): _____
   _____

4. Have you recently or previously had any of the following?

If you answer yes to any of these, please provide specific details:

Trauma/injury involving the head (please be specific) **YES** or **NO**

Date of Injury: _____ **Where did this occur** (location)**?** _____

5. Brain Surgery? **YES** or **NO**
6. Brain Bleeding? **YES** or **NO**
7. Any personal history of a Stroke? **YES** or **NO**
8. Brain Cancer? **YES** or **NO**
9. Radiation therapy and/or chemotherapy to the brain specifically? **YES** or **NO**
10. Previous CT scan? _____ When & Where? _____
11. Previous MRI scan? _____ When & Where? _____