Lahey CLINIC

Diagnostic Radiology Department

Symptom Summary: Brain

Patient Name: _____ Date: _____

Age: _____ Weight: _____ lbs.

If you have any of the following symptoms, please check:

- ❑ nausea ❑ imbalance ❑ decreased vision
- ❑ seizures ❑ difficulty walking ❑ decreased hearing (❑ right ❑ left)
- ❑ dizziness ❑ double vision ❑ ringing in the ears (❑ right ❑ left)
- ❑ headaches Where? _____
- ❑ pain Where? _____
- ❑ numbness Where? _____
- ❑ tingling Where? _____
- ❑ weakness Where? _____

How long have you had these symptoms? _____

Are they a result of an injury or accident? ❑ yes ❑ no

Date of injury: _____ / _____ / _____

Explain: _____

_____

Have you had prior brain or spine surgery? ❑ yes ❑ no

Explain: _____

_____

Have you ever been diagnosed with cancer? ❑ yes ❑ no

What part of the body? _____

Have you had radiation or chemotherapy? ❑ yes ❑ no

Have you had a previous MRI on your brain? ❑ yes ❑ no

❑ Lahey ❑ Other facility _____