CEDARS-SINAI®
S. MARK TAPER FOUNDATION
IMAGING CENTER

DaTscan QUESTIONNAIRE

PATIENT I.D.

Patient Information

Patient Name: _____ Date of scan: _____

Reason for Exam: _____

Patient Medical History

Previous Brain Scans *(CT, MRI, PET, etc.)*? ❑ Yes ❑ No

If yes, where they done at Cedars-Sinai? ❑ Yes ❑ No

Have you had any surgery or radiation to the head? ❑ Yes ❑ No

If yes, when? _____

Do you have a tremor *(shaking)*? ❑ Yes ❑ No

If yes, please specify location: ❑ Hand ❑ Arm ❑ Leg Which side? ❑ Right ❑ Left

Do you have the tremor at rest? ❑ Yes ❑ No

Do you have tremor that is related to an intentional task *(ie: reaching)*? ❑ Yes ❑ No

If yes, doing <u>what task</u> makes your tremor most noticeable? _____

Do you have any walking symptoms *(ie: shuffing)*? ❑ Yes ❑ No Specify: _____

Have you noticed any memory loss? ❑ Yes ❑ No On a scale 1-10 *(10 being severe)* how would you rate your memory loss? _____ How long have you felt a decline in memory?_____

What other symptoms relating to this visit do you have? _____

_____

Are you allergic to Iodine? ❑ Yes ❑ No

Do you have a history of using cocaine? ❑ Yes ❑ No

Are you currently using cocaine? ❑ Yes ❑ No

Do you have any kidney disease? ❑ Yes ❑ No

If yes, what kind? _____

What medication do you take? _____

_____

NAME OF PATIENT (please print)	SIGNATURE OF PATIENT	DATE	TIME
NAME OF TECHNOLOGIST (please print)	**SIGNATURE OF TECHNOLOGIST**	**DATE**	**TIME**