

BRAIN EVALUATION

LAST NAME	FIRST	MIDDLE INIT.	AGE	TODAY'S DATE

THESE QUESTIONS APPLY ONLY TO THE AREA BEING SCANNED TODAY.

1. In one sentence, describe what made you go to see your doctor. _____

2. Do you have headaches? _____ If so, describe: _____

3. Do you have weakness? _____ If so, where? Which side? _____

4. Have you had seizures? _____ If so, what kind? _____

5. Do you have difficulty walking? _____ If so, can you describe it? _____

6. Is your vision normal? _____ If not, can you describe the problem? _____

7. Did the difficulty come on: Gradually Over years Months Weeks Days Suddenly
8. Have you had surgery? _____ If so, what was done? When was it done? _____

9. Have you ever injured your brain? _____ Date of Injury _____

10. Have you had difficulty thinking? _____ Remembering? _____ Calculating? _____

11. Have you had difficulty thinking of the right words? _____ Saying words? _____

12. Have you had difficulty with your balance? _____
13. Describe your health: _____

14. Do you have allergies or asthma? _____ Have you ever had a reaction to x-ray dyes or contrast agents? _____
15. Do you have any medical condition that we should know about? _____

16. Are you taking any medications? What kind? _____
