Neuro/Head Evaluation

Last Name ______________________ First Name ______________________ Middle__________________

Date ______________________________________ Age ______________________________________

THESE QUESTIONS APPLY ONLY TO THE AREA BEING SCANNED TODAY

1. Describe what made you go see your doctor: ______________________________________

   ____

2. Do you have headaches? ☐ Yes ☐ No

3. Headaches where? ______________________________________

   ____

4. Have you had seizures or other CNS deficit (stroke, fainting, etc.)? ☐ Yes ☐ No

5. Have you had any changes in vision, speech, balance, or thinking? ☐ Yes ☐ No

6. Describe changes: ______________________________________

   ____

7. Have you had surgery? ☐ Yes ☐ No

8. Surgery what was done? ______________________________________

   ____

9. Surgery where was it done? ______________________________________

   ____

10. Do you have a history of cancer? ☐ Yes ☐ No

11. Do you have any other medical conditions?______________________________________

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