# BRAIN EVALUATION

| Last Name: | First: | Date: |
|---|---|---|
| | | |

**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 or No (Circle One)
3. Headaches where?
   _____
   _____
   _____
4. Have you had seizures or other CNS deficit (stroke, fainting etc.)? Yes or No (Circle one)
5. Have you had any changes in vision, speech, balance or thinking? Yes or No (Circle one)
6. Describe changes:
   _____
   _____
   _____
7. Have you had surgery? Yes or No (Circle one)
8. What was done?
   _____
   _____
9. Do you have history of cancer? Yes or No (Circle one)
10. Do you have any other medical conditions? Yes or No (Circle one)
11. List conditions:
    _____
    _____
    _____