BRAIN EVALUATION

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<tr>
<th>LAST NAME</th>
<th>FIRST</th>
<th>MIDDLE INIT.</th>
<th>AGE</th>
<th>TODAY’S DATE</th>
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**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? ____________________________