# BRAIN EVALUATION

**THESE QUESTIONS APPLY ONLY TO THE AREA BEING SCANNED TODAY**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle</th>
<th>Today’s Date</th>
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<tr>
<th>Age</th>
<th>Height</th>
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1. Describe what made you go see your doctor: __________________________________________________

_______________________________________________________________________________________

2. Do you have headaches?  
   Yes [ ]  No [ ]

3. Headaches where (ie: front/back of head)? ________________________________________________

_______________________________________________________________________________________

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 on this area?  
   Yes [ ]  No [ ]

8. If yes, what surgery and when? ________________________________________________

_______________________________________________________________________________________

9. Have you had prior imaging of this area?  
   Yes [ ]  No [ ]

10. When and where? ________________________________________________

_______________________________________________________________________________________

11. Do you have a personal history of cancer?  
    Yes [ ]  No [ ]  
    Type _________________

12. Do you have any other medical conditions? ________________________________________________

_______________________________________________________________________________________