Patient Name: ___________________________________ Date of Birth: ______________

Date: _______________

BRAIN EVALUATION

1. Describe what made you seek medical advice: ______________________________
2. Do you have headaches? YES NO

   If yes please describe the location(s) of your headaches: ________________________

   ____
3. Have you had seizures or other neurological event (stroke, fainting etc.)? YES NO

   If yes please describe: ____
4. Have you had any changes of vision, speech, balance or thinking? YES NO

   If yes please describe: ____
5. Have you had surgery to the area being scanned? YES NO

   If yes please describe what type of surgery, date and where surgery was done:

   ____
6. Do you have a history of cancer? YES NO Type: ___________________________
7. Do you have any other medical conditions? _________________________________

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