



HEAD/BRAIN
CLINICAL QUESTIONNAIRE

NAME: _____

DATE: _____

1. Why has your doctor sent you for this test? Did he/she give you a specific diagnosis?

2. Please describe what specific complaints/symptoms have been most bothersome to you?

3. How long have you had these complaints/symptoms? _____

4. Do you have a history of cancer? If so, what type? _____

5. Are these symptoms the: same better worse

6. Do you have weakness on one side of your body? yes no
If yes, which side? right left

7. Have you ever had visual problems? yes no
If yes, please describe: _____

8. Have you ever had memory problems? yes no
If yes, please describe: _____

9. Have you ever had hearing problems? yes no
If yes, please describe: _____

10. Please check if you have any of the following:

- Balance Problems
- High Blood Pressure
- Diabetes
- Kidney Disease
- Old Stroke
- Heart Disease
- Multiple sclerosis
- Cancer
- Other Medical Problems:

When: _____

Type: _____
