

PAIN SHEET

BRAIN EVALUATION

LAST NAME	FIRST	MIDDLE INIT.	AGE	TODAY'S DATE

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? Where was it done? _____

9. Have you had difficulty thinking? _____ Remembering? _____ Calculating? _____
10. Have you had difficulty thinking of the right words? _____ Saying words? _____
11. Have you had difficulty with your balance? _____
12. Describe your health: _____

13. Do you have allergies or Asthma? _____ Have you ever had a reaction to x-ray dyes or contrast agents? _____
14. Do you have any medical condition that we should know about? _____

15. Are you taking any medications? _____ What kind? _____
