PRINT NAME: _____ FILE # _____

Confidential Patient Health Record

"GEORGE'S CEREBROVASCULAR CRANIOCERVICAL FUNCTION TEST"

Instructions: Please check off the correct response.

Historical Information

- **Have you ever been diagnosed or told you have any of the following?**
  1. **High Blood Pressure (hypertension)** ☐ Yes ☐ No
  2. **Hardening of the arteries (arteriosclerosis)** ☐ Yes ☐ No
  3. **Diabetes** ☐ Yes ☐ No
  4. **Heart or blood vessel diseases** ☐ Yes ☐ No
  5. **Bone spurs on the neck bones (cervical spondylosis)** ☐ Yes ☐ No
  6. **Whiplash injury (flexion-extension injury) (cervical spondylosis)** ☐ Yes ☐ No
  7. **Have any of your relatives suffered a stroke?** ☐ Yes ☐ No
  8. **Were you ever a smoker? If yes, from _____ to _____** ☐ Yes ☐ No
  9. **Do you take any medications on a regular basis?** ☐ Yes ☐ No
     - **If yes, what? (Coumadin, Heparin, Aspirin, Anti-hypertensive medicine, etc.)**

     _____
  10. **(Woman Only) Have you ever taken oral Contraceptives?** ☐ Yes ☐ No
      - **If yes, from _____ to _____**

- **Have you ever had any of the following, even short, temporary attacks, in the last year?**
  1. **Blurred Vision** ☐ Yes ☐ No
  2. **Double Vision** ☐ Yes ☐ No
  3. **Diminished or partial loss of vision in one or both eyes** ☐ Yes ☐ No
  4. **Complete loss of vision in one or both eyes** ☐ Yes ☐ No
  5. **Ringing, buzzing or any noise in the ear(s)** ☐ Yes ☐ No
  6. **Hearing loss in one or both ears** ☐ Yes ☐ No
  7. **Slurred speech or other speech problems** ☐ Yes ☐ No
  8. **Difficulty swallowing?** ☐ Yes ☐ No
  9. **Dizziness** ☐ Yes ☐ No
  10. **Temporary lack of understanding** ☐ Yes ☐ No
  11. **Loss on consciousness, even momentary blackouts** ☐ Yes ☐ No
  12. **Numbness or loss of sensation in the face, fingers, hand, arms, legs, or any other parts of your body?** ☐ Yes ☐ No
  13. **Any other abnormal sensations in any part of your body** ☐ Yes ☐ No
  14. **Weakness, clumsiness or loss of strength in the face, finger, hands, arms, or legs** ☐ Yes ☐ No
  15. **Sudden collapse without loss of consciousness** ☐ Yes ☐ No

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Patient's Signature_____ **Date**_____