

Confidential Patient Health Record

“GEORGE’S CEREBROVASCULAR CRANIOCERVICAL FUNCTION TEST”

Instructions: Please circle 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 spine) 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. (Women 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

Patient Signature _____ Date _____