HEAD AND NECK SCREENING QUESTIONNAIRE

NAME: __________________________________________ DATE: _____________
Medical Record #: _________________________

1. Are you currently being treated for high blood pressure?  
2. Have you recently had difficulty with speaking?  
3. Have you noticed an increased clumsiness or weakness in your arms or legs?  
4. Do you frequently have headaches?  
5. Have you noticed a recent decreased ability of concentrate?  
6. Do you experience dizziness?  
7. Have you noticed a recent change in your vision or ability to see?  
8. Have you recently experienced a blow to the head or a whiplash injury?  
9. Have you been experiencing nausea and/or vomiting?  
10. Do you currently have a fever, or have you had a fever recently?  
11. Have you recently been living in close quarters, such as in a dormitory?  
12. Do you have a depressed immune system?  
13. Are your eyes sensitivity to light?  
14. Have you recently had a seizure?