HEAD AND NECK SCREENING QUESTIONNAIRE

NAME: _____ DATE: _____
Medical Record #: _____

	Yes	No
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?	☐	☐