GEORGE'S CEREBROVASCULAR CRANIOCERVICAL FUNCTIONAL TEST

Have you ever been diagnosed with any of the following:

High blood pressure?	Yes ____	No ____
Hardening of the arteries?	Yes ____	No ____
Diabetes?	Yes ____	No ____
Heart disease?	Yes ____	No ____
Stroke?	Yes ____	No ____
Seizures?	Yes ____	No ____

Have you ever experienced any of the following?

Blurred Vision?	Yes ____	No ____
Partial vision loss in one or both eyes?	Yes ____	No ____
Complete vision loss in one or both eyes?	Yes ____	No ____
Ringing or buzzing in your ear/ears?	Yes ____	No ____
Dizziness?	Yes ____	No ____
Difficulty swallowing?	Yes ____	No ____
Slurred speech or other speech problems?	Yes ____	No ____
Temporary lack of understanding?	Yes ____	No ____
Loss of consciousness?	Yes ____	No ____
Momentary blackouts?	Yes ____	No ____
Numbness or loss of sensation anywhere?	Yes ____	No ____

George's Test (For doctor only)   Negative _____   Positive _____

Patient Signature ____ **Date** __________

Print Name ____