

CAROTID CLINICAL INFORMATION SHEET

Name _____ Age _____ Today's Date _____

1. Why are you having this test? _____

2. Do you have pain? _____ If yes, where: _____

If yes, what type and date: _____

3. Do you have any of the following (*please write "YES" next to all that apply*):

a. _____ Dizziness

b. _____ Blurry vision

c. _____ Temporary episodes of blindness

d. _____ Paralysis

e. _____ Tingling

f. _____ Numbness

g. _____ Slurred speech

h. _____ High blood pressure

i. _____ Diabetes

j. _____ Smoking

k. _____ Heart disease

l. _____ Prior surgery, If yes please explain and give date: _____

m. _____ Did the doctor feel a lump in your neck? If yes, please where: _____

4. Did you have a previous CAT scan, MRI, Sonogram or other test which may help interpret this exam? If yes, what? _____ Where? _____

5. Other information which you feel may be helpful: _____
