

George's Test

Patient Portion

Patient Name: _____ Date: _____ Age: _____ Gender: M or F

Please circle the most appropriate response. Please sign and date when finished.

I. Historical Information

Have you ever been diagnosed or told you have any of the following?

Dr.'s Notes

- | | | |
|--|-----|----|
| 1. High blood pressure (hypertension) | Yes | No |
| 2. Hardening of the arteries (arteriosclerosis) | Yes | No |
| 3. Diabetes | Yes | No |
| 4. Heart or blood vessel disease | Yes | No |
| 5. Bone spurs on the neck bones | Yes | No |
| 6. Whiplash (Flexion/Extension injury) | Yes | No |
| 7. Have any of your relatives ever suffered a stroke | Yes | No |
| 8. Were you ever a smoker | Yes | No |
| 9. Do you medicine on a regular basis | Yes | No |
| 10. (Women) Have you taken oral contraceptives | Yes | No |

Have you had any of the following, even short, attacks in the last year?

- | | | |
|--|-----|----|
| 11. Blurred Vision | Yes | No |
| 12. Double Vision | Yes | No |
| 13. Diminished or partial loss of vision in one or both eyes | Yes | No |
| 14. Complete loss of vision in one or both eyes | Yes | No |
| 15. Ringing, buzzing or any noise in the ears | Yes | No |
| 16. Hearing loss in one or both ears | Yes | No |
| 17. Slurred speech or other speech problems | Yes | No |
| 18. Difficulty swallowing | Yes | No |
| 19. Dizziness | Yes | No |
| 20. Temporary lack of understanding | Yes | No |
| 21. Loss of consciousness, even momentary blackouts | Yes | No |
| 22. Numbness or loss of sensation in the face, fingers,
Hands, arms, legs, or other parts of your body | Yes | No |
| 23. Other abnormal sensations in any part of your body | Yes | No |
| 24. Weakness, clumsiness or loss of strength in the face,
fingers, hands, arms, legs, or other parts of your body | Yes | No |
| 25. Sudden collapse without loss of consciousness | Yes | No |

Patient's Signature: _____ **Date:** _____