1. Please check all that apply:
   - Confusion
     - Acute (recently experiencing)
     - Chronic (long term)
   - Vasculitis associated w/wo Lupus
   - Headaches
   - Head Trauma
   - History of Seizures
   - Substance Abuse
   - Gait Problem (unsteady walking)
   - Memory Loss
     - Acute (recently experiencing)
     - Chronic (long term)
   - Motor Difficulties / Inabilities
   - Stroke / CVA: ____________________________

2. Do you have any tremor?  
   - Yes  
   - No

3. Recent Head / Neck Surgeries
   - Yes  
   - No
   - When: ____________________________

4. Do you have allergies to sulfa drugs?  
   - Yes  
   - No

5. Do you have asthma?  
   - Yes  
   - No

Additional Information:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Patient’s Name (print)  
Signature  
Date  
Time

Completed by (print)  
Relation  
Signature  
Date  
Time
**NEUROLITE BRAIN SPECT QUESTIONNAIRE**

To be completed by CNMT:

__________________________
__________________________

This box to be completed by CNMT:

Table height: ______________
Collimator radius: __________

(Affix label)
Diamox Dose Sticker

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<th>Blood Pressure</th>
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(Affix label)
Adenosine Dose Sticker

(Affix label)
Neurolite Dose Sticker

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Tech Name (print)  Signature / Title  Date  Time