Medical Park Imaging

Carotid Doppler Questionnaire

Name:_____Date:_____

Male/Female Referring Physician:_____

Please circle if you have any of the following symptoms:

Headache	**Yes**	**/ No**	**If so how long:_____**
Dizziness	**Yes**	**/ No**	**If so how long:_____**
Ringing in Ears	**Yes**	**/ No**	**If so how long:_____**
Throbbing Pain	**Yes**	**/ No**	**If so how long:_____**
Nausea	**Yes**	**/ No**	**If so how long:_____**
Blurry Vision	**Yes**	**/ No**	**If so how long:_____**
Double Vision	**Yes**	**/ No**	**If so how long:_____**
Loss of Vision	**Yes**	**/ No**	**If so how long:_____**
Vertigo	**Yes**	**/ No**	**If so how long:_____**
Eye Floaters(myodesopsia)	**Yes**	**/ No**	**If so how long:_____**
Bruit in Neck	**Yes**	**/ No**	**If so how long:_____**
History of Artery Disease	**Yes**	**/ No**	**If so how long:_____**