TRI-CITIES OPEN MRI

# BRAIN EXAMINATION

Patient Name _____

Patient Weight_____ Patient Height_____

What are your present symptoms?

_____

When did symptoms begin?

_____

How did this condition occur?

_____

Please circle any symptoms you currently have or previously experienced and tell us how often:

| | Right | Left | Frequency |
|---|---|---|---|
| Weakness | _____ | _____ | _____ |
| Seizures | _____ | _____ | _____ |
| Headaches | _____ | _____ | _____ |
| Visual Problems | _____ | _____ | _____ |
| Hearing Problems | _____ | _____ | _____ |
| Speech Problems | _____ | _____ | _____ |
| Thinking Difficulties | _____ | _____ | _____ |
| Walking Difficulties | _____ | _____ | _____ |
| Ringing/Buzzing in Ears | _____ | _____ | _____ |

Have you had a previous CT or MRI in the past 5 years? If yes, when and where?

_____

Comments:

_____

_____

_____ _____

Patient (Parent/Guardian) Signature Date