

PAIN SHEET

Brain Evaluation

Name			Birth date	Referred by	Today's Date
_____			____/____/____	Dr. _____	____/____/____
Last	First	Middle Init.	mm/dd/yyyy		mm/dd/yyyy

1. In one sentence, describe what made you go to see your doctor. _____

2. Do you have headaches? _____ If so, describe: _____

3. Do you have weakness? _____ If so, where? Which side? _____

4. Have you had seizures? _____ If so, what kind? _____

5. Do you have difficulty walking? _____ If so, can you describe it? _____

6. Is your vision normal? _____ If not, can you describe the problem? _____

7. Did the difficulty come on: Gradually Over years Months Weeks Days Suddenly
8. Have you had surgery? _____ If so, what was done? When was it done? _____

9. Have you had difficulty thinking? _____ Remembering? _____ Calculating? _____

10. Have you had difficulty thinking of the right words? _____ Saying words? _____

11. Have you had difficulty with your balance? _____
12. Describe your health: _____

13. Do you have allergies or Asthma? _____ Have you ever had a reaction to x-ray dyes or contrast agents?

14. Do you have any medical conditions that we should know about? _____

15. Are you taking any medications? _____ What kind? _____

Please complete BOTH sides.

Patient History and Safety Screening
MRI PATIENTS ONLY

Please answer all of the following questions:

YES NO

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | CARDIAC PACEMAKER |
| <input type="checkbox"/> | <input type="checkbox"/> | BRAIN VESSEL CLIPS |
| <input type="checkbox"/> | <input type="checkbox"/> | AORTIC CLIPS |
| <input type="checkbox"/> | <input type="checkbox"/> | ARTIFICIAL HEART VALVE |
| <input type="checkbox"/> | <input type="checkbox"/> | CORONARY, ARTERY OR HEART SURGERY, IF YES, WHEN? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | INSULIN PUMP |
| <input type="checkbox"/> | <input type="checkbox"/> | ELECTRODES |
| <input type="checkbox"/> | <input type="checkbox"/> | TENS UNITS OR PAIN STIMULATING UNIT |
| <input type="checkbox"/> | <input type="checkbox"/> | EAR SURGERY OR IMPLANTS |
| <input type="checkbox"/> | <input type="checkbox"/> | HEARING AIDS |
| <input type="checkbox"/> | <input type="checkbox"/> | METAL FRAGMENTS IN THE HEAD, EYE OR SKIN |
| <input type="checkbox"/> | <input type="checkbox"/> | HAVE YOU EVER WORKED WITH METAL OR AS A METAL WORKER? |
| <input type="checkbox"/> | <input type="checkbox"/> | METAL PLATES, PIN, SCREWS, NAILS OR CLIPS |
| <input type="checkbox"/> | <input type="checkbox"/> | ANY PREVIOUS SKULL SURGERY |

If yes, what was the surgery for: _____

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | IS THERE ANY CHANCE YOU ARE PREGNANT?
(Not recommended for women in their first trimester of pregnancy) |
|--------------------------|--------------------------|--|

Signature of patient: _____

Signature of parent or guardian: _____

Date: _____

Please complete BOTH sides