Orthopedic Care Specialists
NEURO

NAME: _____ **DATE:** _____ **DOB:** _____

Have you been having headaches? Y N

Have you been having seizures? Y N

If yes, when? _____

Facial numbness or tingling? Y N

Arm or Leg numbness? Y N

If yes which arm? **Left** **Right** **Both**
If yes which leg? **Left** **Right** **Both**

Arm or Leg tingling? Y N

If yes which arm? **Left** **Right** **Both**
If yes which leg? **Left** **Right** **Both**

Do you have dizziness? Y N

Do you have double vision? Y N

Blurry Vision? Y N

If yes which eye? **Left** **Right** **Both**

Decrease in hearing? Y N

If yes, which ear? **Left** **Right** **Both**

Ringing in ears? Y N

If yes, which ear? **Left** **Right** **Both**

How long have you had these symptoms?

Day(s) _____ **Week(s)** _____ **Month(s)** _____ **Year(s)** _____

Have you had prior MRIs? **Yes** **No**

If yes, what area was imaged? Which facility? _____

Have you ever been diagnosed with cancer? Y N

If yes, what kind? _____

TECH. COMMENTS: _____

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