MedStar Health

MEDSTAR NEUROSURGICAL ASSOCIATES
Patient Information

CRANIAL SYMPTOMS

Please DESCRIBE all that apply

Patient Name:_____ **DOB:**_____ **Age:**_____

Please state your main complaint:_____

_____

Date of onset/duration:_____

Was there an Initial injury?: yes no

Describe any Injury:_____

_____

Headache_____

Nausea, Vomiting, Appetite Change_____

Change in Vision, Hearing, Smell or Taste_____

Facial Numbness, Tingling or Weakness_____

Change in Speech_____

Change in Reading or Writing_____

Loss/Change of Memory_____

Loss/Change of Mental Functions_____

Emotional/Behavioral Change_____

Weakness in Arms or Legs_____

Loss of Balance_____

Falls_____

Numbness or Tingling in Body, Arms, Legs_____

Change in Bladder Control_____

Change in Bowel Control_____

Seizures_____

Other Brain Disorders_____

Prior Brain Surgery_____

Any previous episodes of above complaints? No Yes If Yes, When:_____

Please describe prior symptoms:_____

Symptoms aggravated by:_____

Symptoms improved by:_____

Any other associated symptoms/depression/sleeping problem?_____

_____

Treatments tried:_____

Are activities restricted?_____

Tests performed: none/ spine x-rays/MRI/CT scan /EEG/other_____