MEDSTAR NEUROSURGICAL ASSOCIATES
Patient Information

CRANIAL SYMPTOMS
PLEASE DESCRIBE ALL THAT APPLY

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_____