NEW PATIENT ASSESSMENT

Name: _____

Date: _____

What are your main symptoms?

_____

_____

_____

Please advise if you have any of the items below.

Defibrillator _____ **Pacemaker _____**

Heart Stents _____ **Aneurysm Clips _____**

Have you had a mastectomy? _____

Pins/Screws (if yes, please indicate where they are located in the area below) _____

_____

_____

Have you had any of the following tests in the last six months?

_____ CT Brain **_____ MRI Brain**

_____ MRA Brain and Neck **_____ MRI Spine**

_____ EEG **_____ EMG/NCV**

_____ Carotid Ultrasound **_____ Echocardiogram**

If so, when and where? _____

_____

Have you been hospitalized within the last year? _____

If yes, when and where? _____