BRIEF PATIENT INFORMATION
For Initial MRI Review Purposes Only

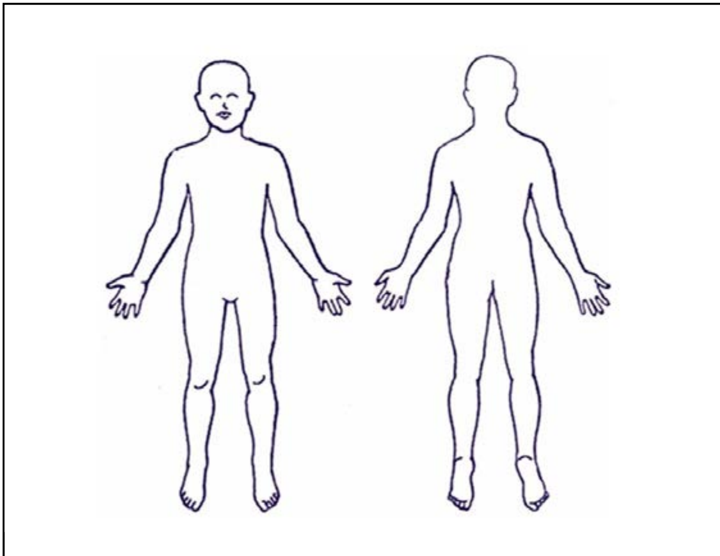
NAME: ____________________________ AGE:________
GENDER: _________ WEIGHT _______ HEIGHT________

Please describe your symptoms and concerns:

What DATE it started and what were the circumstances associated with it.

SHADE THE AREAS WHERE YOU HAVE THE PROBLEM:

FRONT BACK



PREVIOUS SURGERIES (and date):

By signing below and submitting the information for courtesy review, you acknowledge that this is for informational review only and does not represent any form of diagnosis, offer of treatment, and does not state nor imply any formation of a doctor-patient relationship. A formal neurosurgical consultation and establishment of care can only be done in person, without exception.

Unsigned submissions will be deleted without response. Please do not contact the office for the status of your submission.

PATIENT SIGNATURE:_______________________________________ DATE:_____________________

Quoc-Anh Thai, MD, FAANS, FACS