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Cranial Nerves Examination

Name: _____ SSN: _____

Date of Exam: _____ C-number: _____

Place of Exam: _____

A. Review of Medical Records:

B. Medical History (Subjective Complaints):

Comment on:

1. Onset, course since onset.
2. Symptoms.
3. Current treatment, response, side effects.
4. Effects of condition on occupational functioning and daily activities.
5. History of hospitalization or surgery, location and dates, if known, reason or type of surgery.
6. History of trauma to a cranial nerve, date, type, nerve.
7. History of neoplasm:
 - a. Date of diagnosis, diagnosis.
 - b. Benign or malignant.
 - c. Types of treatment, dates.
 - d. Last date of treatment.

C. Physical Examination (Objective Findings):

Address each of the following and fully describe current findings:

1. Describe in detail specific motor and sensory impairment, quantifying as much as possible.
2. If smell or taste is affected, please also complete the appropriate worksheet.

D. Diagnostic and Clinical Tests:

1. Include results of all diagnostic and clinical tests conducted in the examination report.

E. Diagnosis:

1. Identify the nerve and the side.
2. Identify the disorder (i.e., paralysis, neuritis, neuralgia).
3. State etiology.

Signature:

Version: 2007

Date: