MRI- Guided Focused Ultrasound
Patient Screening Questionnaire

Patient Information
Name (First, Last):
Date of Birth:
Address:
Phone number:
Email:
How did you learn about this treatment?

Insurance Information
Primary insurance name:
Primary insurance ID number:
Secondary insurance name (if applicable):
Secondary insurance ID number:

Health Questions

1. Have you been formally diagnosed with an essential tremor by a healthcare professional? YES/NO
2. How many years have you had your essential tremor symptoms?
3. Please circle or highlight all the anti-tremor medications you have tried or are currently taking for your tremors:

    - Propranolol,
    - Primidone,
    - Gabapentin,
    - Topiramate,
    - Lorazepam,
    - Diazepam,
    - Clonazepam,
    - Mirtazapine,
    - Botox,
    - Other:

4. Do you have any metal implants or medical devices (pacemaker, ICD, spine stimulator, deep brain stimulator, pins, rods, shunts, clips) that would prevent you from having an MRI? YES/NO

5. What tasks are you having difficulty completing due to your tremor?

PLEASE FAX OR MAIL THIS FORM TO HEATHER WISNER AT:
FAX: 801-581-4385
MAILING ADDRESS: 175 N MEDICAL DR, SALT LAKE CITY, UT 84132