**Please indicate the signs and symptoms the patient reported for her intracranial hypertension.**

### Symptoms Signs

***Y N `Y N***

****  ****  Headache ****  ****  Bilateral Papilledema

****  ****  Transient Visual Obscurations (TVOs) ****  ****  Unilateral Papilledema

****  ****  Blurred Vision ****  ****  Visual Acuity Tests (worse than 20/20 corrected)

****  ****  Tinnitus ****  ****  Perimetry (Some type of defect present)

****  ****  Diplopia ****  ****  Other:

****  ****  Neck Stiffness

****  ****  Arthralgias of shoulders, wrists, or knees

****  ****  Ataxia

****  ****  Facial palsy

****  ****  Radicular pain

****  ****  Other:

**Please indicate if the patient’s condition satisfied the following conditions:**

***Y N***

****  ** Signs and symptoms of increased intracranial pressure**

****  ** No localizing findings on neurologic exam**

  Normal MRI/CT scan with no evidence of venous obstructive disease

 If abnormal, please list findings:

****  ** Opening CSF pressure: > 250 mmH2O with normal CSF constituents**

Position ****  Prone

****  Sitting

****  Lateral Decubitus

Highest Opening Pressure: mmH2O

****  ** Awake and alert patient**

****  ** No known cause of increased intracranial pressure found**

**  Secondary intracranial hypertension due to:**

**Printed Physician Name Specialty**

**Signature of Physician Date**