



CEDARS-SINAI MEDICAL CENTER
Department of Neurosurgery

ADULT & PEDIATRIC BRAIN & SPINE TUMOR MEDICAL HISTORY FORM EDUCATIONAL SCAN REVIEW PROGRAM

PATIENT INFORMATION:

Name : LAST _____ FIRST _____ Age: _____ Male Female DOB: ___/___/___
 Address: _____ City _____ State _____ Zip Code: _____
 Family Contact: _____ Relationship: _____ Patient SS# _____
 Phone: (Day) _____ (Evening) _____ (Fax) _____ (Email) _____

PRIMARY CARE PHYSICIAN:

LAST _____ FIRST _____
 Address: _____ City _____ State _____ Zip Code: _____
 Phone: _____ Fax: _____ Email: _____

PATIENT'S INITIAL NEUROLOGICAL DEFICITS, SYMPTOMS, AND COMPLAINTS:

• _____

PATIENT'S CURRENT NEUROLOGICAL DEFICITS, SYMPTOMS, AND COMPLAINTS:

• _____

IMAGING STUDIES, i.e. MRI, CT, PET [Specify Type, Findings and Date(s)]:

• _____

DIAGNOSIS: Date of Diagnosis: _____ Right Handed Left Handed

Current Date(s) of Tumor Progression/Recurrence:
 • _____

Patient Dx: Tumor Type
 • _____

PRIOR TREATMENT: Yes No If Yes, Please provide Date(s) Performed:

<u>Surgery</u>			
Open biopsy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stereotactic biopsy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tumor Removal & Percentage Removed	<input type="checkbox"/>	<input type="checkbox"/>	_____
<u>Radiation therapy</u>			
External/Focused beam	<input type="checkbox"/>	<input type="checkbox"/>	_____
Whole brain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neuroaxis	<input type="checkbox"/>	<input type="checkbox"/>	_____
<u>Chemotherapy</u>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please list names and dates of therapies/drugs: _____
<u>Clinical Trials</u>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please list names and dates of therapies/drugs: _____
<u>Genetic Studies</u>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please list names and dates: _____
<u>Alternative therapies</u>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please list names and dates: _____

PREVIOUS RECOMMENDATIONS ?

• _____

WHAT IS/ARE THE MOST IMPORTANT QUESTION(S) YOU WANT US TO ANSWER?

• _____

HOW DID YOU HEAR ABOUT US? Magazine Article Internet Cedars/MDNSI Website
 Physician referral Friend Radio Ad Other (revised 07/10)

Scan Reviews being sent from outside of California and Michigan, must be filled out, submitted & signed below by a referring MD:

 Treating Physician Name (Printed) Treating Physician Signature State Date