



CEDARS-SINAI MEDICAL CENTER

Department of Neurosurgery

ADULT & PEDIATRIC HYDROCEPHALUS 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: _____

DIAGNOSIS

Date of Diagnosis: _____ Diagnosis: _____

PATIENT'S DAILY LEVEL OF FUNCTIONS: Independent: Needs assistance Dependent

PATIENT'S CURRENT DEFICITS, SIGNS, SYMPTOMS AND COMPLAINTS

- _____
- _____
- _____

Etiology (Cause):

Congenital (born with hydrocephalus)

Yes No

Intraventricular hemorrhage of newborn:

Yes No

Infection:

Yes No

Tumor:

Yes No

Idiopathic (unknown):

Yes No

Shunt Procedure: :

Yes No If Yes, please provide date(s) performed _____

Third Ventriculostomy:

Yes No If Yes, please provide date(s) performed _____

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 08/10)

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Treating Physician Name (Printed)

Treating Physician Signature

State

Date