



**CEDARS-SINAI MEDICAL CENTER**  
**Department of Neurosurgery**

**Adult & Pediatric 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 CURRENT SIGNS, SYMPTOMS AND COMPLAINTS**

**Headaches:**

Yes  No

**Made Worse by Valsava (bearing down):**

Yes  No

**Nausea/Vomiting:**

Yes  No

**Scoliosis:**

Yes  No

**Swallowing Difficulty:**

Yes  No

**Raspy Voice:**

Yes  No

**Neck Pain:**

Yes  No

**SURGICAL PROCEDURES**

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

**Posterior Fossa Craniectomy with:**

Cervical Laminectomy   \_\_\_\_\_

Dural Graft   \_\_\_\_\_

**CSF Diversion Procedure:**

Ventriculoperitoneal Shunt   \_\_\_\_\_

Lumboperitoneal Shunt   \_\_\_\_\_

**Postoperative Improvement in Signs and Symptoms?** Yes  No

**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)

*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