CEDARS-SINAI MEDICAL CENTER®

Department of Neurosurgery

ADULT & PEDIATRIC SPINAL DISORDERS -- MEDICAL HISTORY FORM FOR 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 DAILY LEVEL OF FUNCTIONING: Independent ☐ Needs assistance ☐ Dependent ☐

PREOPERATIVE

Neurological Signs and Symptoms: ____

Bladder Studies and Results: ____

Curve & how many degrees ____

	Yes	**No**	**Name(s)/Date(s)**
Associated Anomalies:			
Syndromes (list)	☐	☐	________________________
Chiari Malformation	☐	☐	________________________

POSTOPERATIVE	**Yes**	**No**	**Date(s)**
Bladder Studies:			
Improved	☐	☐	________________________
Unchanged	☐	☐	________________________
Worse	☐	☐	________________________
Pain			
Back Pain	☐	☐	________________________
Leg Pain	☐	☐	________________________
Other			
Curve & Degree	☐	☐	________________________
Fusion	☐	☐	________________________
Revision Surgery	☐	☐	________________________
Re-tethering & Operation?			
Number One			
Number Two			

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