



CEDARS-SINAI MEDICAL CENTER
Department of Neurosurgery

ADULT & PEDIATRICS NEUROVASCULAR 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 _____

DIAGNOSIS
 Brain aneurysm: Arteriovenous Malformation: Stroke: Date of stroke: _____
 Date of Diagnosis: _____ Right Handed Left Handed
 Patient's Diagnosis/Pathology: _____

PATIENT'S CURRENT NEUROLOGICAL SYMPTOMS, DEFICITS AND COMPLAINTS
 • _____
PATIENT'S DAILY LEVEL OF FUNCTIONING : Independent Needs assistance Dependent

We require the information below, so if you are unsure of any answers, please ask your doctor.
PRIOR TREATMENT

	Yes	No	DATE(S) PERFORMED:
Aneurysm:			
Clipping	<input type="checkbox"/>	<input type="checkbox"/>	_____
Coiling	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bypass	<input type="checkbox"/>	<input type="checkbox"/>	_____
Balloon angioplasty	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arteriovenous Malformation:			
Microsurgery	<input type="checkbox"/>	<input type="checkbox"/>	_____
Endovascular surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____
Coils or glue	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke:			
Clot busting drugs (thrombolytics)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Surgery: bypass (revascularization)	<input type="checkbox"/>	<input type="checkbox"/>	_____

Clinical Trials?
 If yes, please list trials, institution and dates
 • _____
Alternative Therapies?
 If yes, please list trials, institution 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 Website
 Physician referral Friend Radio Ad Other _____ (Rev. 07/10)

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

_____ State _____ Date _____
 Treating Physician Name (Printed) Treating Physician Signature