



CEDARS-SINAI MEDICAL CENTER

Department of Neurosurgery

CHIARI MALFORMATION -- MEDICAL HISTORY FORM FOR OUTSIDE 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 01/02)

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Treating Physician Name (Printed) Treating Physician Signature State Date