



CEDARS-SINAI MEDICAL CENTER.

Department of Neurosurgery
Maxine Dunitz Neurosurgical Institute

PEDIATRIC BRAIN -- TUMOR 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: _____

PATIENT'S INITIAL NEUROLOGICAL DEFICITS, SYMPTOMS, AND COMPLAINTS:

• _____

PATIENT'S CURRENT NEUROLOGICAL DEFICITS, SYMPTOMS, AND COMPLAINTS:

• _____

IMAGING STUDIES, i.e. MRI, CT, PET [Specify Type, Findings and Date(s)]:

• _____

DIAGNOSIS: Date of Diagnosis: _____ Right Handed Left Handed

Current Date(s) of Tumor Progression/Recurrence:

• _____

PRIOR TREATMENT: Yes No If Yes, Please provide Date(s) Performed:

Surgery

Open biopsy _____

Stereotactic biopsy _____

Tumor Removal & _____

Percentage Removed

Radiation therapy

External/Focused beam _____

Whole brain _____

Neuroaxis _____

Chemotherapy

 If yes, please list names and dates of therapies/drugs:

Clinical Trials

 If yes, please list names and dates of therapies/drugs:

Genetic Studies

 If yes, please list names and dates:

Alternative therapies

 If yes, please list names 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 Website Physician referral

(Revised 04/07) Friend Radio Ad Other _____