



CEDARS-SINAI MEDICAL CENTER
Department of Neurosurgery

NEUROVASCULAR -- 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

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. 01/02)

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