



CEDARS-SINAI MEDICAL CENTER
Department of Neurosurgery

ADULT 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) _____

TREATING PHYSICIAN:

LAST _____ FIRST _____
 Address: _____ City _____ State _____ Zip Code: _____
 Phone: _____ Fax: _____ Email: _____

DIAGNOSIS

Date of Diagnosis: _____ Right Handed Left Handed
 Patient's Diagnosis/Tumor Type: _____

PATIENT'S CURRENT SYMPTOMS AND ANY CURRENT DATES OF TUMOR PROGRESSION NOTED:

• _____

PATIENT'S DAILY LEVEL OF FUNCTIONING : Independent Needs assistance Dependent

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

Surgery

Open biopsy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stereotactic biopsy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tumor Removal	<input type="checkbox"/>	<input type="checkbox"/>	_____

Radiation therapy

External/Focused beam	<input type="checkbox"/>	<input type="checkbox"/>	_____
Whole brain	<input type="checkbox"/>	<input type="checkbox"/>	_____

Radiosurgery

X-knife	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gamma knife	<input type="checkbox"/>	<input type="checkbox"/>	_____

Chemotherapy

<input type="checkbox"/>	<input type="checkbox"/>	If yes, please list names and dates of therapies/drugs: _____
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Clinical Trials

<input type="checkbox"/>	<input type="checkbox"/>	If yes, please list names and dates of therapies/drugs: _____
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Alternative therapies

<input type="checkbox"/>	<input type="checkbox"/>	If yes, please list names and dates: _____
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PREVIOUS RECOMMENDATIONS?

• _____
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WHAT IS/ARE THE MOST IMPORTANT QUESTION(S) YOU WANT US TO ANSWER?

• _____

HOW DID YOU HEAR ABOUT US? Magazine Article Internet Cedars/Neurosurgery Website
 Physician referral Friend Radio Ad Other (revised 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