



CEDARS-SINAI MEDICAL CENTER
Department of Neurosurgery

PEDIATRIC EPILEPSY -- 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) _____

PATIENT'S EPILEPTOLOGIST/NEUROLOGIST: LAST _____ FIRST _____
 Address: _____ City _____ State _____ Zip Code: _____
 Phone: (Day) _____ (Fax) _____ (Email) _____

DATE OF CLINICAL DIAGNOSIS: _____ Right Handed Left Handed

PATIENT'S CURRENT NEUROLOGICAL DEFICITS, SIGNS, SYMPTOMS, AND COMPLAINTS:
 • _____

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

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

CLINICAL INFORMATION:

Seizure Type(s): Unknown
 • _____

Average Number of Seizures Per Week at Time of Surgery:
 • _____

Name(s), dosage (strength) and schedule of Anticonvulsant(s) Tried Prior to Surgery: None
 • _____

EEG Localization and Date: Yes No Preoperative Invasive Monitoring:
 • _____ Yes No

Surgical Complications and Dates: Yes No
 • _____

Results at 6 Months: _____ Results at 1 Year: _____

Alternative therapies: Yes No
 If yes, please list with 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/MDNSI Website
 Physician referral Friend Radio Ad Other (revised 01/02)

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 Treating Physician Name (Printed) Treating Physician Signature State Date