



**CEDARS-SINAI MEDICAL CENTER**  
**Department of Neurosurgery**

**SPINAL CORD MALFORMATIONS -- 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 DAILY LEVEL OF FUNCTIONING:** Independent  Needs assistance  Dependent

**DIAGNOSIS**  
 Date of Diagnosis: \_\_\_\_\_ Diagnosis: \_\_\_\_\_  
 Location: Cervical:  Thoracic:  Lumbosacral:

**PREOPERATIVE**  
 Neurological Signs and Symptoms:  
 • \_\_\_\_\_  
 Bladder Studies and Results:  
 • \_\_\_\_\_

	Yes	No	Name(s)/Date(s)
<b>Associated Anomalies:</b>			
Syndromes (list)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chiari Malformation	<input type="checkbox"/>	<input type="checkbox"/>	_____

<b>POSTOPERATIVE</b>	Yes	No	Date(s)
<b>Bladder Studies:</b>			
Improved	<input type="checkbox"/>	<input type="checkbox"/>	_____
Unchanged	<input type="checkbox"/>	<input type="checkbox"/>	_____
Worse	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Retethering &amp; Operation?</b>			
Number One	<input type="checkbox"/>	<input type="checkbox"/>	_____
Number Two	<input type="checkbox"/>	<input type="checkbox"/>	_____

**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)

*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