



CEDARS-SINAI MEDICAL CENTER
Department of Neurosurgery
Maxine Dunitz Neurosurgical Institute

HYDROCEPHALUS – 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

Name: 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 _____

PATIENT'S CURRENT DEFICITS, SIGNS, SYMPTOMS AND COMPLAINTS

- _____
- _____
- _____

Etiology (Cause):

	Yes	No	
Congenital (born with hydrocephalus)	<input type="checkbox"/>	<input type="checkbox"/>	
Intraventricular hemorrhage of newborn	<input type="checkbox"/>	<input type="checkbox"/>	
Infection	<input type="checkbox"/>	<input type="checkbox"/>	
Tumor	<input type="checkbox"/>	<input type="checkbox"/>	Type _____
Idiopathic (unknown) <input type="checkbox"/>			

Shunt Procedure:

If yes, list date(s) _____

Third Ventriculostomy:

PREVIOUS RECOMMENDATIONS?

- _____
- _____

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

- _____
- _____

HOW DID YOU HEAR ABOUT US?

Magazine Article Radio Ad Cedars-Sinai Website Friend
 Physician Referral Other _____