CEDARS-SINAI MEDICAL CENTER
Department of Neurosurgery

Welcome and thank you for choosing the **Department of Neurosurgery at Cedars-Sinai Medical** for your healthcare needs.

Our mission is to provide first order clinical care for patients with disorders affecting the central nervous system, to improve treatments through cutting-edge research and educate patients, clinicians, scientists and community, ensuring the continuation of innovations in neuroscience. Depending on the nature of your visit, you may be asked to complete forms and participate in interviews conducted by members of our dedicated *Patient Care Team*. This information is used to develop a plan of care for you.

Attached you will find:

1. **Referring Physician Form**
2. **Patient Health History Form**
3. **Driving Directions and Parking Information**

Please complete items 1 and 2 above and be sure to **bring your most recent MRI scans (all pages of all sets) and medical records** related to your current medical condition. This information is necessary in order to perform a complete and thorough consultation. We also ask that you bring your current health insurance card and photo identification card.

Since our office uses an electronic medical record system, we do not maintain any patient records in our office. When requesting medical records generated by our medical staff, please contact the Health Information Department at Cedars-Sinai Medical Center at (310) 423-2259. For copies of your imaging studies or reports, please call the S. Mark Taper Foundation at Cedars-Sinai Medical Center at (310) 423-8000, option 2.

As part of our ongoing effort to improve the quality of care and service provided to our patients and guests, we ask that you complete the service satisfaction survey (provided to you at the conclusion of your visit) and return it to us in the box provided. Self-addressed return envelopes are also available upon request for your convenience.

Sincerely,

Keith L. Black, M.D.
Chairman

CEDARS-SINAI MEDICAL CENTER
Department of Neurosurgery

REFERRING PHYSICIAN FORM

PATIENT NAME _____ **MRN** _____ **NSI MD** _____

HOW WERE YOU REFERRED TO US?

☐ Physician Referral ☐ Friend/Family Referral ☐ Self Referral ☐ Media
☐ 1-800 Cedars-1 ☐ Publication ☐ Internet ☐ Other

If referred by physician, please complete: Referring MD Name _____

Address _____ City/State _____Zip _____

Tel No (___)_____ Fax No. (___)_____

PLEASE PUT √ (s) IN THE APPROPRIATE BOXES IF YOU WOULD LIKE A LETTER SENT TO ANY OF THE FOLLOWING:

☐ **INTERNIST/FAMILYMD**_____
Address _____
City/State _____ Zip _____
Tel No (___)_____ Fax No (___)_____

☐ **REHAB MD**_____
Address _____
City/State _____ Zip _____
Tel No (___)_____ Fax No (___)_____

☐ **NEUROSURGEON**_____
Address _____
City/State _____ Zip _____
Tel No (___)_____ Fax No (___)_____

☐ **NEURO ONCOLOGIST**_____
Address _____
City/State _____ Zip _____
Tel No (___)_____ Fax No (___)_____

☐ **NEUROLOGIST**_____
Address _____
City/State _____ Zip _____
Tel No (___)_____ Fax No (___)_____

☐ **OTHER MD**_____
Address _____
City/State _____ Zip _____
Tel No (___)_____ Fax No (___)_____

☐ **PEDIATRICIAN**_____
Address _____
City/State _____ Zip _____
Tel No (___)_____ Fax No (___)_____

☐ **OTHER MD**_____
Address _____
City/State _____ Zip _____
Tel No (___)_____ Fax No (___)_____

I hereby authorize the Department of Neurosurgery at Cedars-Sinai Medical Center to furnish information to the physicians identified above.

_____ _____ _____
Print Name of Patient Signature of Patient Date

CEDARS-SINAI MEDICAL CENTER
Department of Neurosurgery

PATIENT HEALTH HISTORY

PATIENT NAME: _____ **DATE OF BIRTH:** ___/___/___

DATE OF APPOINTMENT: ____/____/____ **DOCTOR'S NAME:** _____

Reason for today's visit: _____

Please list any prior major illnesses and /or injuries:

_____

_____

_____

Are you currently experiencing any pain? ❒ Yes ❒No ❒Acute ❒ Chronic

If yes, please rate your pain _____ (Scale 0 to 10)
Location and frequency of pain _____

Are you allergic to any medications? ❒ Yes ❒ No
If yes, please list medication name(s) and reaction(s) _____
_____

Current Medications	Dose (i.e. mg)	Frequency

Have you ever had problems with anesthesia? ❒ Yes ❒ No
If yes, please describe problem and drug name: _____
_____

PROCEDURES and TREATMENTS

Surgeries (Type)	Date (Mo/Day/Yr)	Complications

PATIENT NAME _____ **MRN** _____

Radiation Therapy	Start and End Dates	No. of Cycles or Boosts

Chemotherapy	Start and End Dates	No. of Cycles

Do you already possess Directives (i.e. Advance, Power of Attorney) ❒Yes ❒ No
(If yes, please bring a copy for your medical records on file to next appointment)

REVIEW of SYSTEMS

Are you currently, or have you had, problems with:

General	**Circle One**	
Fever	Yes	No
Weight Loss	Yes	No
Weight Gain	Yes	No
Excessive Fatigue	Yes	No
Night Sweats	Yes	No
Eyes		
Wear Glasses—Date of Last Exam: _____	Yes	No
Infections	Yes	No
Injuries	Yes	No
Glaucoma	Yes	No
Cataracts	Yes	No
Floaters	Yes	No
Left Blindness	Yes	No
Right Blindness	Yes	No
Blurred Vision	Yes	No
Double Vision	Yes	No
Left Peripheral Vision Loss	Yes	No
Right Peripheral Vision Loss	Yes	No
Right or Left Enucleation	Yes	No
Ear, Nose, Throat and Mouth		
Wear Hearing Aids Date of Last Exam: _____	Yes	No
Hearing Loss	Yes	No
Ear Pain	Yes	No
Ear Infections	Yes	No
Ringing In Ears Circle: Left Right Both	Yes	No
Difficulty or Pain with Swallowing	Yes	No
Nosebleeds	Yes	No
Nasal Congestion	Yes	No

PATIENT NAME _____ **MRN** _____

Ear, Nose, Throat and Mouth	**Circle One**	
Nasal Drainage Amount_____ Color_____	Yes	No
Inability to Smell	Yes	No
Sinus Problems	Yes	No
Sinus Headaches	Yes	No
Sore Throats	Yes	No
Mouth Sores	Yes	No

Cardiovascular		
Chest Pain or Angina—Date of Last EKG: _____	Yes	No
Arrythmia	Yes	No
High Blood Pressure	Yes	No
Irregular Pulse	Yes	No
Heart Murmur	Yes	No
High Cholesterol	Yes	No
CHF	Yes	No
CHD	Yes	No
Swelling in Feet or Hands	Yes	No
Leg Pain while Walking	Yes	No

Respiratory		
Asthma	Yes	No
Chronic Cough	Yes	No
Emphysema	Yes	No
Shortness of Breath	Yes	No
Bronchitis	Yes	No
Pneumonia	Yes	No
Lung Cancer	Yes	No
Bloody Sputum	Yes	No
Date of Last Chest X-ray: _____		

Gastrointestinal		
Indigestion	Yes	No
Nausea	Yes	No
Vomiting	Yes	No
Blood in your Vomit	Yes	No
Liver Disease	Yes	No
Jaundice	Yes	No
Abdominal Pain	Yes	No
Diarrhea	Yes	No
Constipation	Yes	No
Appetite Disturbance	Yes	No
Ulcers	Yes	No
Gastritis	Yes	No

PATIENT NAME _____ **MRN** _____

Genitourinary	**Circle One**	
Urinary Tract Infections	Yes	No
Painful Urination	Yes	No
Blood in your Urine	Yes	No
Difficulty Starting or Stopping Stream	Yes	No
Incontinence	Yes	No
Kidney Stones	Yes	No
Prostate Cancer (males)	Yes	No
Endometriosis (females)	Yes	No
Uterine or Cervical Cancer (females)	Yes	No

Musculoskeletal		
Numbness	Yes	No
Tingling	Yes	No
Broken Bones—List: _____	Yes	No
Arm or Leg Weakness	Yes	No
Back Pain	Yes	No
Arm or Leg Pain	Yes	No
Joint Pain or Swelling	Yes	No
Arthritis	Yes	No
Cervical Pain (CP)	Yes	No
Scoliosis	Yes	No
Musculosclerosis (MS)	Yes	No
Achondroplasia	Yes	No
Spinal Stenosis	Yes	No
Cerebral Palsy	Yes	No
Spinabifida	Yes	No

Integumentary		
Skin Disease	Yes	No
Skin Cancer	Yes	No
Wound or Incision's Integrity	Yes	No
Breast Pain, Tenderness or Swelling (females)	Yes	No
Nipple Discharge (females)	Yes	No
Date and Result of Last Mammogram (females)	Yes	No

Neurological		
Balance Disturbance	Yes	No
Dizziness	Yes	No
Fainting Spells or "Blacking Out"	Yes	No
Seizures Date of Last Seizure _____	Yes	No
Sleep Disturbance	Yes	No
Problems with Your Memory	Yes	No
Disorientation	Yes	No
Speech deficits	Yes	No
Inability to Concentrate	Yes	No
Face Weakness	Yes	No
Coordination in Arm and/or Legs	Yes	No

PATIENT NAME _____ **MRN** _____

List assistant devices used _____
List activity restrictions _____

Psychiatric	**Circle One**	
Anxiety	Yes	No
Depression	Yes	No
Panic Attacks	Yes	No
Hallucinations	Yes	No
OCD (Obsessive Compulsive Disorder)	Yes	No
Personality Changes	Yes	No

Have you ever seen a mental health professional such as psychiatrist, psychologist or councelor?
❒ Yes ❒ No
If so, please answer the following:
When _____
Why _____
What psychiatric medication _____
Duration of treatment _____

Endocrine		
Diabetes	Yes	No
Thyroid Disease	Yes	No
Increased Appetite	Yes	No
Excessive Thirst or Urination	Yes	No
Hormone Problems	Yes	No
Cushing's Disease	Yes	No

Hematologic/Lymphatic		
Anemia	Yes	No
Hemophilia	Yes	No
Bleeding Tendencies	Yes	No
Persistent Swollen Glands or Lymph Nodes	Yes	No
Blood Transfusion	Yes	No

If yes, when? _____

Allergic/Immunologic		
Food Allergies	Yes	No
Inhalant (nasal) Allergies	Yes	No
Immunologic Disorders	Yes	No

Pediatric Patients ONLY:

Pregnancy Complication (s): ❒ Yes ❒No Describe_____
Delivery type (mother): ❒ Caesarian section ❒ Vaginal ❒ Adopted
Delivery Complications ❒Yes ❒No Describe _____

PATIENT AME _____ **MRN** _____

PATIENT PROFILE

Family Member	Alive	Deceased	Age	Health Status & Cause of Death

Has anyone in your family had brain tumor? ❒ Yes ❒ No
Has anyone in your family had a brain aneurysm? ❒ Yes ❒ No
Occupation _____
Marital Status ❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Other
Do you have children? _____

Tobacco Use: ❒ current ❒ previous ❒ never Started: _____
❒ Cigarettes Amt: _____ packs per day
❒ Cigars/pipes Amt: _____ # per week
❒ Smokeless/Chewing Amt: _____ per day
Counseled to quit/cut down: ❒ Yes ❒No
Year quit: _____

Alcohol: ❒ Yes ❒No Average drink(s) per day: _____
Type: _____ Counseled: ❒ Yes ❒ No

Drugs: ❒ Yes ❒ No
Drug Choice: ❒ marijuana ❒ cocaine ❒ crack ❒ heroin
❒ illicit RX ❒ other: _____
Comments: _____

Other:
Passive smoker exposure: ❒ Yes ❒ No
Caffeine Use (drinks/day) ❒ 1 ❒ 2 ❒ 3 ❒ 4 ❒ 5+
Exercise (times/week): ❒ 0 ❒ 1 ❒ 2 ❒ 3 ❒ 4
❒ 5 ❒ 6 ❒ 7 ❒ >7
Types of Exercise: _____
Seatbelt use (%) ❒ 0 ❒ 25 ❒ 50 ❒ 75 ❒ 100
Sun Exposure: ❒ frequently ❒ occasionally ❒rarely

Living Status/Support Systems:
Housing: ❒ apartment
❒ house
❒ condo/townhouse
❒ other
Living Status: ❒ lives alone
❒ unable to care for self
❒ lives w/ family/friend/attendant
❒ difficult access/steps
❒ home health care
❒ other _____
Need Social Services Assess: ❒ Yes ❒ No

PATEINT NAME _____ **MRN** _____

Patient Rights:

Cultural & Spirituality: ❒ No cultural/spiritual issues
Beliefs/Practice Effecting TX: _____
_____

Healthcare Decisions:

❒ makes own medical decisions
❒ medical decisions made jointly b/w patient/family
❒ family members make major decisions
❒ has advance directive
❒ copy given to CSMC

Family/Self Participation in Care/Recovery:

❒ patient desires to be active in planning care
❒ patient desires family to be active in planning care
❒ patient desires friend to be active in planning care
❒ family able & willing to participate in learning about care
❒ friend able & willing to participate in learning about care

Health Maintenance Considerations:

Current immunizations: ❒ Yes ❒ No
Exposure to communicable disease discussed: ❒ Yes ❒ No
Date flu shot rcvd: _____
Intervention/Notes: _____

The above information is accurate to the best of my knowledge.

_____ _____/_____/_____
Patient Signature Date

I have reviewed the above information with the patient.

_____ _____/_____/_____
Physician Name (Printed) & Signature Date

_____ _____/_____/_____
RN Name (Printed) & Signature Date

CEDARS-SINAI MEDICAL CENTER
Department of Neurosurgery

The Department of Neurosurgery Patient Care Team is dedicated to caring for the whole person. We recognize that dealing with a medical condition can have a significant emotional impact on a person's life. To help us in providing the best care possible please respond to the following questions.

1. In what manner has your neurological problem caused impairments in your ability to function at work, socially, or in your routine daily activities?

2. Are you presently experiencing distressing emotional symptoms, such as:

_____ sleep disturbance
_____ appetite disturbance
_____ anxiety reactions
_____ panic attacks
_____ memory difficulties
_____ hallucinations or unusual behavior (noted by others)
_____ depression
_____ obsessive thoughts
_____ compulsive behaviors
_____ increased use of alcohol
_____ increased use of recreational drugs
_____ personality changes (noted by self or others)

Please describe any of the above items:

3. Have you ever seen a mental health professional such as psychiatrist, psychologist or counselor? ___ Yes _____No
If so, please include when, why, and duration of treatment.

4. Are you presently taking any form of psychiatric medication? ____Yes ____No
If so, please list names and dosages:

5. Are there any other concerns you have (about your current situation) that the treatment team should be aware of?

8631 West Third Street, Suite 800-E ■ Los Angeles, CA 90048
Office (310) 423-7900 ■ Fax (310) 423-0777 ■ E-mail csnsi.edu ■ www.csmc.edu/nsi

CEDARS-SINAI MEDICAL CENTER
Department of Neurosurgery

Driving Directions/Parking Information

Extension 32100 to 76500

Driving Directions to CSMC Medical Towers

8631 West Third St. Suite 800-E Los Angeles, CA 90048

- **San Fernando Valley or Ventura County**

Take the 101 South to the 405 South to the 10 East, exit on Robertson Blvd., (North) to 3rd street make a right to Sherbourne make a left and parking lot 4 is on your right hand side.

- **LAX, Beach Cities or Orange County**

Take the 405 North to the 10 East, exit on Robertson Blvd., (North) to 3rd street make a right to Sherbourne make a left and parking lot 4 is on your right hand side.

- **Pasadena, Duarte or Cities near the 134 and 210 Freeways**

Take the 110 South to the 10 West , exit on Robertson Blvd., (North) to 3rd street make a right to Sherbourne make a left and parking lot 4 is on your right hand side.

- **Monterey Park, El Monte, Baldwin Park or Cities near the 10 and 60 Freeways**

Take the 10 west, exit on Robertson Blvd., (North) to 3rd street make a right to Sherbourne make a left and parking lot 4 is on your right hand side.

- **From Westwood, Sherman Oaks or Van Nuys**

Take the 405 South to the 10 East, exit Robertson Blvd., (North) to 3rd street make a right to Sherbourne make a left and parking lot 4 is on your right hand side.

YOU WILL RECEIVE A LONG BLUE TICKET, WHICH IS AN INDICATION THAT YOU ARE IN THE CORRECT PARKING STRUCTURE. YOU MAY ALSO PARK IN LOT 7 WHICH IS AN OPEN LOT NEXT TO PARKING LOT 4.

PLEASE REMEMBER TO BRING YOUR FILMS, HEALTH INSURANCE CARD AND PHOTO IDENTIFICATION CARD WITH YOU TO YOUR APPOINTMENT.