Minnesota Epilepsy Group, P. A.

225 Smith Ave N., Suite 201 Saint Paul, MN 55102 (651) 241-5290

Pediatric Patient Data

Date: _____

Patient Name _____ Sex: M / F

Nickname _____ Age _____ Date of Birth _____/_____/_____

Street Address: _____

City _____ State _____ County _____ ZIP _____

Phone Number (_____) _____ SS#: _____-_____-_____

Race (Please check the correct box)

□ American Indian or Alaskan Native
□ Asian
□ Native Hawaiian or Other Pacific Islander
□ Black or African American
□ White
□ Hispanic
□ Other Race
□ Other Pacific Islander
□ Unreported/Refused to Report
□ Unknown

Ethnicity (Please check the correct box)

□ Hispanic or Latino
□ Not Hispanic or Latino
□ Refused to Report

Language(s) Spoken_____

Parent or Guardian Information:

Name _____ Relationship _____

Street Address: _____

City _____ State _____ ZIP _____

Phone Number Home: (_____) _____ Work: (_____) _____

Past Medical Data

From whom should we request your medical records? Please include clinic name, first and last names of doctors, complete addresses and telephone numbers. Please list additional sources of treatment on back.

Physician treating child for seizures:_____ Specialty: _____

Name of Clinic: _____

Street Address: _____

City _____ State _____ ZIP _____

Phone Number: (_____) _____ Dates of care:_____

Physician:_____ Specialty: _____

Name of Clinic: _____

Street Address: _____

City _____ State _____ ZIP _____

Phone Number: (_____) _____ Dates of care:_____

Physician:_____ Specialty: _____

Name of Clinic: _____

Street Address: _____

City _____ State _____ ZIP _____

Phone Number: (_____) _____ Dates of care:_____

Physician: _____ Specialty: _____
Name of Clinic: _____
Street Address: _____
City _____ State _____ ZIP _____
Phone Number: (_____) _____ Dates of care: _____
Who would you like your clinic note sent to? _____

List all hospitalizations from birth to present. Continue on next page.

Name of Hospital Where Child was born _____
Address _____
City _____ State _____ ZIP _____
Dates of hospitalization _____ Reason for hospitalization _____
Phone: _____

Name of Hospital _____
Address _____
City _____ State _____ ZIP _____
Dates of hospitalization _____ Reason for hospitalization _____
Phone: _____

Name of Hospital _____
Address _____
City _____ State _____ ZIP _____
Dates of hospitalization _____ Reason for hospitalization _____
Phone: _____

Name of Hospital _____
Address _____
City _____ State _____ ZIP _____
Dates of hospitalization _____ Reason for hospitalization _____
Phone: _____

Hospitalizations in the last 12 months:
number of seizure-related: _____
number of other medical: _____
number of psychiatric-related: _____
number of other: _____
number of seizure-related emergency room visits in the last 12 months: _____
number of other emergency room visits in the last 12 months: _____

Past Diagnostic Tests Performed
When was his/her last EEG? _____
Has your child ever had:
a seizure during an EEG recording? _____ Yes _____ No
a combined video/EEG recording? _____ Yes _____ No
skull X-rays: _____ Yes _____ No Where performed: _____
spinal tap: _____ Yes _____ No Where performed: _____
chromosomes: _____ Yes _____ No Where performed: _____
blood or urine tests: _____ Yes _____ No Where performed: _____
looking for cause of seizures: _____ Yes _____ No Where performed: _____

CAT (CT) Scan-History

Has your child ever had a CAT or CT scan of the head? Yes_____ No_____

If yes, please complete for most recent CT scan:

Name of Facility _____

Address _____

City _____ State _____ ZIP _____

Telephone (____)_____ Date Completed _____

Results, if known _____

MRI (Magnetic Resonance Imaging) History

Has your child ever had an MRI scan of the head? Yes_____ No_____

If yes, please complete for most recent MRI scan:

Name of Facility _____

Address _____

City _____ State _____ ZIP _____

Telephone (____)_____ Date Completed _____

Results, if known _____