Adult New Patient History and Demographics

MN EpilepsyGroup
Focused expertise. Comprehensive care.

Demographics:

Date: ____/____/____

Last Name:	First Name:	Preferred Name:	
Date of Birth: __/__/__	Age:	Handedness: Right Left Both	
Street Address:			
City:	State:	Zip Code:	County:
Is this a residential facility? Yes No	Name of Facility and Contact:		
Home Phone:	Cell Phone:	Work Phone:	
Preferred Contact Method: (Circle): Home Cell Work			

Race:

American Indian		Alaskan Native		African American/Black	
Native Hawaiian		Pacific islander		Asian	
Hispanic		White Caucasian		Other/Prefer not to Identify	

Country of Origin: _____ Languages Spoken: _____

Legal Custody:

Self: ☐ Other: ☐ (If other, please list under guardianship information)

Guardianship Information:

Last Name:	First Name:		
Street Address:			
City:	State:	Zip Code:	County:
Home Phone:	Cell Phone:	Work Phone:	
Preferred Contact Method: (Circle): Home Cell Work			

Emergency Contact:

Last Name:	First Name:		
Street Address:			
City:	State:	Zip Code:	County:
Home Phone:	Cell Phone:	Work Phone:	

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Family Medical History:

Relation:	Age:	Seizure/Epilepsy History?	Other Health Issues:	Deceased?	Cause of Death:
Mother:					
Father:					
Sisters					
Brothers:					
Maternal Grandfather:					
Maternal Grandmother:					
Paternal Grandfather:					
Paternal Grandmother:					
Additional:					

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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. Skip items if not applicable.

1. Physician Currently Treating Patient for Seizures:		
Clinic Name:	Street Address:	
City:	State:	Zip:
Phone #: ( )	Dates Under Care:	

2. Primary Care Physician:		Clinic Name:
Street Address:		
City:	State:	Zip:
Phone #: ( )	Dates Under Care:	

3. Other Specialist Name:		Clinic Name:
Street Address:		
City:	State:	Zip:
Phone #: ( )	Dates Under Care:	

Past Diagnostic Tests Performed (Skip if not applicable)

Electroencephalogram (EEG) History

Name of Facility:		
Street Address:		
City:	State:	Zip Code:
Phone #:	Date of EEG:	
Results if Known:		

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CAT (CT) Scan History – Please Complete for Most Recent CT if Applicable

Name of Facility:		
Street Address:		
City:	State:	Zip Code:
Phone #:	Date of Scan:	
Results if Known:		

Magnetic Resonance Imaging (MRI) History – Please Complete for Most Recent MRI if Applicable

Name of Facility:		
Street Address:		
City:	State:	Zip Code:
Phone #:	Date of Scan:	
Results if Known:		

Hospitalizations/Emergency Room Visits in the past year:

Number of seizure-related: _____

Number of other medical: _____ Reasoning: _____

Number of seizure-related emergency room visits in the last 12 months: _____

Number of other emergency room visits in the last 12 months: _____

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List most pertinent hospitalizations if any:

Name of Hospital:		
Street Address:		
City:	State:	Zip Code:
Phone #:	Dates of Hospitalization:	
Reason for hospitalization:		

Name of Hospital:		
Street Address:		
City:	State:	Zip Code:
Phone #:	Dates of Hospitalization:	
Reason for hospitalization:		

Employment

What is your employment status?	Full time		Part Time		Other		Retired	
Name and City of Employer:								
Have you ever lost a job due to your seizures?	Yes / No							

Are you driving? Yes ◯ No ◯

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Seizure History

Age of first seizure: _____ Date of first seizure: _____
Circumstances surrounding first seizure: _____

Seizure Type Description: *Please describe all types of events patient has had to date.*

Type:	Appearance	Average Duration	Average Frequency	Date of Last Seizure:
First Seizure Type Patient Had:				
Type 2:				
Type 3:				
Type 4:				

Longest period of seizure freedom: _____

Have seizures interfered with your life and goals? If so, how?

_____

_____

_____

Does anything seem to trigger your seizures?

_____

_____

_____

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Medications:

Current Anti-Epileptic Medications (AED)

Drug Name: *Example: Keppra*	Dose: *Example: 1000mg*	Times Medication Taken: Example: 1000mg @8am and 1500mg @8pm

Prior Seizure Medications Tried:

Drug Name: *Example: Keppra*	Dose: *Example: 1000mg*	Reason stopped:

Other Medications:

Drug Name:	Dose:	Times Medication Taken:

Allergies (Medication Name or other known allergies and reaction): _____

_____

Any other information you would like us to know:

What do you hope will be accomplished during your evaluation at Minnesota Epilepsy Group?

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