Pediatric New Patient History and Demographics

Please fill out all information to the best of your ability.

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Focused expertise. Comprehensive care.

Patient Demographics:

Date: ____/____/____

Last Name:	First Name:	Preferred Name:	
Parent 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			

Patient's 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:

Parent ☐ 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 unknown)

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) – 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:		

Education

What grade in school is the patient in now?	
Name and City of School:	
Is the patient enrolled in special education course?	Yes / No
Does the patient have an IEP	Yes / No
Any concerns regarding schooling for the patient?	

Is the patient 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 the patient's life and goals? If so, how?

_____

_____

_____

Does anything seem to trigger the patient's seizures?

_____

_____

_____

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Medications:

Current Anti-Epileptic Medications (AED)

Drug Name: *Example: Keppra*	Dose: *Example: 500mg*	Times Medication Taken: Example: 500mg @8am and 1500mg @8pm

Prior Seizure Medications Tried:

Drug Name: *Example: Keppra*	Dose: *Example: 500mg*	Reason stopped:

Other Medications:

Drug Name:	Dose:	Times Medication Taken:

Are any of your child's medications to be taken at school? _____

Does your child take medications independently? _____

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

_____

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Developmental History

Pregnancy and Birth:
Duration of pregnancy: _____ weeks *(i.e. 34 weeks)*
Were there any complications with pregnancy? (i.e. UTI, Accident, Seizures, Substance Abuse, Bleeding, diabetes, etc.)

Please list: _____

_____

Was the delivery: (Please Circle) Natural Induced C-Section

Any complications with delivery? (i.e. breach, forceps used, need for oxygen) _____

_____

APGAR Scores if known: _____ @ 1 min

_____ @ 5 min

Did the patient have any problems following birth such as seizures, cyanosis, jaundice or other? Please list: _____

_____

_____

Concerns for Developmental Milestones *Please list any concerns you have when it comes to appropriate milestones for the patient's age* https://www.cdc.gov/ncbddd/actearly/milestones/index.html		
Fine Motor Skills	Examples: Grasping objects within reach, picking up small objects, buttoning clothing, tying shoes, using crayons, able to feed self	Concerns:
Gross Motor Skills:	Examples: Picks head up, rolls over, crawls, standing, walking, climbing	Concerns:
Coordination Skills:	Examples: Riding a bike, jumping, skipping, cutting with scissors, using both a knife and fork, color inside lines	Concerns:
Language Skills:	Examples: Coos, Says single word, says complete sentences, reading, understands simple commands, tells time	Concerns:

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Alternative Communication

If the patient does not communicate verbally are they able to communicate with: (Circle)

Pointing Gestures Sign Language Communication Board

Behavior and Personality

Please describe the patient's behavior and personality traits and list any concerns you have regarding them:

_____

_____

_____

_____

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

_____

_____

_____

_____

_____

_____