Minnesota Epilepsy Group, P.A.
Adult Patient Data

Date: _____

Patient Name _____ Sex: M / F

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

Street Address _____

City _____ State _____ County _____ ZIP _____

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

Other: (_____) _____ 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 _____

Guardianship Information:

Name_____ Relationship _____

Street Address _____

City _____ State _____ County _____ ZIP _____

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

Past Medical Information

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 you for seizures: _____ Specialty: _____

Name of Clinic: _____

Address _____

City _____ State _____ ZIP_____

Phone: (_____) _____ Dates of care _____

Physician: _____ Specialty: _____
Name of Clinic: _____
Address _____
City _____ State _____ ZIP_____
Phone: (_____) _____ Dates of care _____

Physician: _____ Specialty: _____
Name of Clinic: _____
Address _____
City _____ State _____ ZIP_____
Phone: (_____) _____ Dates of care _____

List all Psychiatrist/Psychologist/Counseling Services. Please list any other Counseling Services on back.

Psychiatrist/Psychologist/Counseling Services _____
Specialty: _____
Address _____
City _____ State _____ ZIP_____
Phone: (_____) _____ Dates of care _____

List all recent hospitalizations. Please list any hospitalizations on back.

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: (_____) _____

CAT (CT) Scan – History

Have you 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_____

Phone (_____) _____ Date of test: _____

Results, if known _____

MRI (Magnetic Resonance Imaging) History

Have you ever had an MRI scan of the head? Yes _____ No _____

If yes, where:

Name of Facility _____

Address _____

City _____ State _____ ZIP_____

Phone (_____) _____ Date of test: _____

Results, if known _____