Minnesota Epilepsy Group, P.A.
Adult Patient History

Date: ________________

Patient Name ____ Sex: M / F

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

Street Address ____

City ______________________ State ____________ County ________________ ZIP ____________

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

Other: (_____) _____________________ SS#: _________ - _________ - _________

Send correspondence to the following name/address(s):

Name ____

Street Address ____

City_________________________________ State __________________ ZIP __________________

Name of person filling out this form ____________________________ Relationship________________

Legal Custody:

____ Self ____ Mother ____ other relative ____ Ward of state

____ Joint ____ Father ____ Guardian, non-relative ____ other __________________

Name and Address of Next of Kin:

Name____ Relationship ________________________

Street Address ____

City ______________________ State ____________ County ________________ ZIP ____________

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

In Case of Emergency, Please Contact:

Name____ Relationship ________________________

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

Residential Facility Information:

Name of Facility ____

Street Address ____

City ______________________ State ____________ County ________________ ZIP ____________

Name of Contact Person: ____

Phone: ___________________________________

Medications currently taken for seizures:

Drug	Pill Size(s)	Doses in 24 hours	Time (with dose medication) taken
Example: Dilantin	*100 mg* *30 mg*	*330 mg*	*8 a.m. 130 mg 8 p.m. 200 mg*

Other Medication:

Drug	Dose	Taken For

List all seizure medications prescribed in the past:

Drug	Why Stopped

Allergies: ____

Seizure History

Age at first seizure ______________ Date of first seizure ______________________________________

Describe the events of the first seizure/spell. What were the circumstances surrounding the first seizure? What was the seizure like?

____

____

____

____

____

____

To your knowledge, what are the names of your seizure types?

1. ______________________________ 3. ______________________________
2. ______________________________ 4. ______________________________

What is the longest period of time that you have been seizure-free?

____

Please describe each of your seizure types and how often you have each type.

Type #1: ____

____

____

____

____

____

Type #2: ____

____

____

____

____

____

Type #3: ____

____

____

____

____

____

Type #4: ____

____

____

____

____

Are you employed? Yes ____ No ____ If not, when did you work last? ________________________

Have you ever lost a job because of your seizures? Yes _____ No _____ please explain: ____________

____

____

Have seizures interfered with your life? If so, how? ____
____
____
____
____

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