Minnesota Epilepsy Group, P. A.

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

Pediatric Patient History

Date: _____

Patient Name _____ Sex: M / F

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

Street Address: _____

City _____ State _____ County _____ ZIP _____

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

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 Number: _____

Send correspondence to the following name and address:

Name _____

Address_____

City _____ State _____ ZIP _____

Name _____

Address_____

City _____ State _____ ZIP _____

Will your religious beliefs affect any treatment that will be rendered: ___ Yes ___ No

Comments: _____

Medications currently taken for seizures:

Drug	Size of tablet in mg/tablet or mg/ml-liquid	When medication taken (times)	Total daily dose (mg)

In your judgment, is your child presently experiencing medication side effects? If so, what are they?

_____

_____

_____

_____

Do you know what your child's most recent antiepileptic drug levels were?

Drug	Level	Date of Level

List all seizure medications prescribed in the past:

Past Drug	Highest Daily Dose	Why Discontinued

Does your child take his/her medications independently? _____

How often does your child miss his/her medications? _____

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

If your child takes medications other than the ones for seizures, please list:

Drug	Dose	Taken For

Seizure History

Age of onset of seizures _____ Date of onset of seizures _____

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 child's seizure types?

1. _____ 3. _____

2. _____ 4. _____

Did your child have seizures related to fever as a baby? _____

What brings on your child's seizures? (Check all that apply)

____ No clear precipitating factors
____ Startle
____ Emotional Stress
____ Fatigue
____ Lack of sleep
____ Foods
____ Change in eating habits
____ Known low blood sugar
____ Menstruation (periods)
____ Ovulation
____ Failure to take medications
____ Taking other medications
____ Illness
____ Fever
____ Pain
____ Constipation
____ Exercise
____ Hyperventilation (fast breathing)
____ Breath holding
____ Reading
____ Sounds
____ Lights
____ School
____ Sex
____ Alcohol
____ Alcohol withdrawal
____ Television/video games
____ Don't know

Other General Information

Have the seizures changed how your child acts in any way (please mark all that apply)?

_____ No
_____ Plays less with friends
_____ Does not do things that He/she used to
_____ Grades have gone down
Other _____
_____
_____

Do any of the following describe your child? If so, please mark those that apply.

_____ Not alert, sleepy	_____ Drooling	_____ Frequent infections
_____ Pale and listless	_____ Weight Loss	_____ Headaches
_____ Bad behavior	_____ Puffiness in eyes/fingers	_____ Loss of appetite
_____ Rash	_____ Gum Swelling	_____ Upset stomach
_____ Poor coordination	_____ Unsteady on feet	_____ Slurred speech
_____ Bleeding/Bruising easily	_____ Yellowish colored skin/eyes	_____ Constipation
_____ Dizziness	_____ Hyperactive	_____ Diarrhea
_____ Jitters	_____ Weight gain	

How did you learn of this program?

_____ Physician	_____ Psychologist
_____ Nurse	_____ Social Worker
_____ Voluntary organization	_____ another patient
_____ Newsletter, magazine, etc.	_____ Other _____
_____ Counselor	

Name _____
& Address of
Above _____
Street Address

_____
City State County Zip

In the space provided in the next 2 pages, please describe as completely as possible what your child's seizures are like. You may need to gather additional information from others who have observed your child's seizures. If your child has several types of seizures, please use a separate page for a description of each seizure type.

Describe each seizure type from beginning to end. We have found that the best seizure descriptions are those which use everyday language and no medical terminology. Include the following information in your descriptions:

- Does your child have a warning when one is going to happen? If yes, what is it like?
- How does the seizure begin?
- Is the onset sudden (a few seconds) or gradual (up to a minute or more)?
- How long does the seizure last?
- What does your child do during the seizure?
- Does he/she remember events that occur during the seizure?
- Does he/she lose consciousness, partially or completely, during the seizure?
- How does your child behave after a seizure (does he/she become irritable, confused, sleepy, resume activity, other)?

Type #1: _____

Summary:				**Seizure frequency:**	
Warning or aura:	No	Yes	Sometimes	How many: _____	If frequency is less than one per year, what is the total number of this type of seizure?
Loss of consciousness:	No	Yes	Sometimes	Frequency:	
Confusion afterwards:	No	Yes	Sometimes	___ hour ___ day ___ week ___ month ___ year	_____

Time of seizure occurrence:	
___ Morning ___ During sleep ___ Afternoon ___ Before or during period ___ Evening ___ Other _____ ___ No particular time of day	When was the last time a seizure of this type occurred? _____ _____

Type #2: _____

Summary:				**Seizure frequency:**	
Warning or aura:	No	Yes	Sometimes	How many: _____	If frequency is less than one per year, what is the total number of this type of seizure?
Loss of consciousness:	No	Yes	Sometimes	Frequency:	
Confusion afterwards:	No	Yes	Sometimes	___ hour ___ day ___ week ___ month ___ year	_____

Time of seizure occurrence:	
___ Morning ___ During sleep ___ Afternoon ___ Before or during period ___ Evening ___ Other _____ ___ No particular time of day	When was the last time a seizure of this type occurred? _____ _____

Type #3: _____

_____

_____

_____

_____

_____

Summary:				**Seizure frequency:**	
Warning or aura:	No	Yes	Sometimes	How many: _____ Frequency: ___ hour ___ day ___ week ___ month ___ year	If frequency is less than one per year, what is the total number of this type of seizure? _____
Loss of consciousness:	No	Yes	Sometimes		
Confusion afterwards:	No	Yes	Sometimes		

Time of seizure occurrence:	
___ Morning ___ During sleep ___ Afternoon ___ Before or during period ___ Evening ___ Other _____ ___ No particular time of day	When was the last time a seizure of this type occurred? _____ _____

Type #4: _____

_____

_____

_____

_____

_____

Summary:				**Seizure frequency:**	
Warning or aura:	No	Yes	Sometimes	How many: _____ Frequency: ___ hour ___ day ___ week ___ month ___ year	If frequency is less than one per year, what is the total number of this type of seizure? _____
Loss of consciousness:	No	Yes	Sometimes		
Confusion afterwards:	No	Yes	Sometimes		

Time of seizure occurrence:	
___ Morning ___ During sleep ___ Afternoon ___ Before or during period ___ Evening ___ Other _____ ___ No particular time of day	When was the last time a seizure of this type occurred? _____ _____

Health History: Child

A. Pregnancy and birth history:
Duration of pregnancy (answer full term if delivery was within two weeks of expected time).
_____ Full term
_____ Premature How early? _____ Weeks
_____ Overdue How late? _____ Weeks

Were there any complications with pregnancy? _____Yes _____No

If yes, please mark all that apply:

_____ Urinary infections
_____ Accidents
_____ Seizures
_____ Substance abuse (alcohol, drugs)
_____ X-rays
_____ Vaginal infections of any kind
_____ Bleeding or spotting
_____ High blood pressure
_____ Toxemia
_____ Measles/Rubella
_____ Diabetes
_____ Any illness with a fever
_____ Other _____

B. Labor and delivery
Length of labor: _____ hours
Was the delivery: _____Natural
_____Induced
_____C-Section
Were there any problems during delivery? ____ Yes ____ No
Forceps used ____ Yes ____ No
Born breech ____ Yes ____ No
Did the baby breathe immediately? ____ Yes ____ No

Child's birth weight: _____

APGAR Scores if known: _____ at 1 minute
_____ at 5 minutes
_____ Other

C. Newborn history:
Did your child have any problems following birth? ____ Yes ____ No
If yes, please mark all that apply:
____ Jaundice (Yellow)
____ Cyanosis (Blue)
____ Seizures
____ Other _____

Length of newborn hospital stay? _____

Did the baby have problems feeding? ____ Yes ____ No

If yes, explain: _____

Additional Comments: _____

D. Developmental Milestones

For the following items, please mark those things your child can do, and the age at which she/he learned it. Respond in months, or years and months. If you cannot remember the exact age, list the approximate age.

Example: Age: 2 months OR 3 years 4 months

1. Fine Motor and Self-Care Skills

_____	Grasps objects within reach	Age: _____
_____	Transfers objects from hand to hand	Age: _____
_____	Picks up small objects (Cheerios)	Age: _____
_____	Uses spoon or fork to feed self	Age: _____
_____	Buttons large buttons	Age: _____
_____	Can dress self, except tying shoes	Age: _____
_____	Uses pencil or crayon to scribble	Age: _____
_____	Uses pencil or crayon to draw recognizable pictures	Age: _____
_____	Prints letters	Age: _____
_____	Can print or write name	Age: _____
_____	Is toilet regulated	Age: _____
	(stays dry if placed on the toilet on a regular schedule)	Age: _____
_____	Is toilet trained	Age: _____
_____	Can care for self with minimal supervision	Age: _____
_____	Ties shoes	Age: _____

2. Motor Development and Coordination

_____	Picks head up	Age: _____
_____	Rolls over	Age: _____
_____	Crawls	Age: _____
_____	Sits with support	Age: _____
_____	Sits without support	Age: _____
_____	Stands, holding onto something	Age: _____
_____	Stands alone	Age: _____
_____	Walks, holding on	Age: _____
_____	Walks alone	Age: _____
_____	Climbs	Age: _____
_____	Runs	Age: _____
_____	Rides a trike	Age: _____
_____	Rides a bike	Age: _____

3. Language Skills

_____	Coos or gurgles	Age _____
_____	Babbles (repeats same sound over and over)	Age: _____
_____	Imitates sounds (babbling that sounds like real speech)	Age: _____
_____	Says single word	Age: _____
_____	Says two to three words	Age: _____
_____	Says sentences	Age: _____
_____	Says rhymes, poems	Age: _____
_____	Understands and responds to yes and no command	Age: _____
_____	Understands and can comply with simple commands ("sit down")	Age: _____
_____	Follows directions of 2-3 parts (go to your room, pick up your toys and hang up your clothes)	Age: _____
_____	Counts	Age: _____
_____	Reads	Age: _____
_____	Writes cursive	Age: _____
_____	Does simple math	Age: _____
_____	Tells time	Age: _____

Do you think your child's speech and language is normal? _____ Yes _____ No
If no, explain _____
_____

4. Alternate Communication
(If your child does not speak, please complete this section.)

_____	Points to indicate want	Age: _____
_____	Uses gestures	Age: _____
_____	Uses sign language	Age: _____
_____	Uses a communication board	Age: _____

5. Behavior (Please mark any term that you think describes your child at least half the time)

_____ Active child	_____ Cooperative	_____ Friendly
_____ Easygoing	_____ Moody	_____ Talkative
_____ Shy	_____ Aggressive	_____ Selfish
_____ Cries easily	_____ Helpful	_____ Attentive
_____ Short attention span	_____ Wide mood swings	_____ Hyperactive
_____ Has a strong temper	_____ Withdrawn	_____ Overdependent
_____ Irritable	_____ Depressed	_____ Impulsive
_____ No confidence	_____ Poor self-esteem	

What concerns do you have about your child's behavior? _____
_____
_____

What does your child enjoy doing (favorite toys, activities)? _____

_____

_____

How long will he/she stay with an activity he/she enjoys (approximate number of minutes)?

_____

6. Other

Does your child have emotional problems? _____ Yes ____ No

Please describe: _____

Has he/she had counseling for emotional problems? _____ Yes _____ No

Does your child sleep well? _____ Yes _____ No

Do you think your child is usually happy? _____ Yes _____ No

Does your child get along well with other children? _____ Yes _____ No

Do you have problems with discipline? _____ Yes _____ No

Does your child seem to have frequent accidents or injuries? _____ Yes _____ No

Does your child smoke? _____ Yes _____ No

Does your child drink alcohol? _____ Yes _____ No

Does your child have problems seeing? _____ Yes _____ No

____Wears glasses ____Contact lens

Does your child have problems hearing? _____ Yes _____ No

____Hearing aid

Is your child on a special diet? _____ Yes _____ No

If yes, describe _____

Is your child well coordinated? _____ Yes _____ No

Does your child have good muscle strength? _____ Yes _____ No

Does your child have any problems with sense of touch? _____ Yes _____ No

Does your child use special devices to walk? _____ Yes _____ No

If yes, please mark:

____ Crutches ____ Wheelchair

____ Cane ____ Prosthesis

____ Walker

Is your child: _____ right-handed _____ left-handed _____ undetermined

How does your child do with fine finger skills (drawings, cutting, coloring)?

____ Poor _____ Fair ____ Good

E. Childhood Diseases/Illnesses

1. Mark any illness your child has had since infancy.

___ Ear infections _____ Hay fever _____ frequent colds _____ Bowel or bladder problems

___ Headaches _____ Encephalitis _____ Hives _____Other _____

___ Rashes _____ Meningitis

2. Is your child allergic to any medications? _____ Yes _____ No
   Drug name Reaction (rash, difficulty breathing, etc.)

   _____ _____

   _____ _____

   _____ _____

   Has your child ever had an allergic reaction to X-ray dyes? _____
   Does your child have any food or other allergies (please list)? _____

3. Describe in detail any injury that caused loss of consciousness, confusion or a dazed state.
   a. _____
   b. _____
   c. _____

4. Does your child have any other chronic conditions or illnesses other than epilepsy?
   Yes _____ No _____ If yes, please describe:

   _____

   _____

   _____

5. Immunizations

Please marks the shots your child has had:	Was this series completed?	
_____ DPT	_____ Yes	_____ No
_____ MMR	_____ Yes	_____ No
_____ Polio	_____ Yes	_____ No
_____ TB Test	_____ Yes	_____ No
_____ HIB	_____ Yes	_____ No

   Any reaction to immunizations? Please explain: _____

   _____

F. Family History
   Name of child's father: _____ Age: _____
   Name of child's mother: _____ Age: _____

Name of brother(s):	Birth date	Names of sister(s):	Birth date

(Continue on back if more than four of each)

Have any immediate family members (child's mother, father, brother(s), sister(s) ever had seizures or other neurological problems? ___ Yes ___ No If yes, describe:

Name	Description

Have any immediate family members (child's mother, father, brother(s), sister(s) ever been developmentally delayed? ___ Yes ___ No If yes, describe:

_____

_____

Have any other family members (grandparents, aunts, uncles, cousins) even had seizures or other neurological problems? ___ Yes ___ No If yes, describe:

Name	Relation	Problem

School

What grade is your child in now? (circle the appropriate grade)
Daycare Preschool KG 1 2 3 4 5 6 7 8 9 10 11 12

Is your child enrolled in special classes? _____ Yes _____ No

If yes, please state name of program: _____
Do you consider his/her schoolwork to be satisfactory? _____ Yes _____ No
Does your child enjoy school? _____ Yes _____ No
Has your child missed more than five days of school in the past year? _____ Yes _____ No
Was this because of his/her seizures? _____ Yes _____ No
Has your child repeated a grade in school? _____ Yes _____ No
If yes, which one? _____
Have you ever been told that your child has a learning disability? _____ Yes _____ No
Do you think your child has problems with any of the following?

_____ Reading
_____ Sitting still
_____ Arithmetic
_____ Speech or language
_____ Memory
_____ Spelling
_____ Getting assignments done
_____ obeying the teacher
_____ Writing/printing
_____ Paying attention
_____ Other _____

School/Therapy

Please complete the information requested below for school(s) your child has attended in the last five years. List additional schools on the back.

Name of School _____

Address _____

City_____ State _____ ZIP _____

Telephone (_____) _____ Dates Attended:_____

Contact Person _____ Telephone (_____) _____

Name of School _____

Complete Address _____

City_____ State _____ ZIP _____

Telephone (_____) _____ Dates Attended: _____

Contact Person _____ Telephone (_____) _____

Has/does your child receive: PT - physical therapy: _____ Yes _____ No
ST - speech therapy: _____ Yes _____ No
OT - occupational therapy:_____ Yes _____ No

If yes, please complete the information requested below for facilities where therapy was/is received.

Name of School _____

Address _____

City_____ State _____ ZIP _____

Telephone (____) _____ Dates Attended _____Therapy: PT ____ ST ____OT ___

Name of School _____

Address _____

City_____ State _____ ZIP _____

Telephone (____) _____ Dates Attended _____Therapy: PT ____ ST ____OT ___

Has your child ever had psychological or rehabilitation evaluations: _____ Yes ____ No
If yes, please provide information about where and when evaluations were performed.

Name of School _____

Address _____

City_____ State _____ ZIP _____

Telephone (____) _____ Dates Attended _____Therapy: PT ____ ST ____OT ___

Name of School _____

Address _____

City_____ State _____ ZIP _____

Telephone (_____) _____ Dates Attended: _____ Psychological ____ Rehabilitation ___