Pediatric New patient History and Demographics

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

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 contact:	
Home Phone:	Cell Phone:	Work Phone:
Preferred Contact Method: Home Cell Work		

Patient Identity:

Birth Sex: Male Female Unknown					
Gender Identity:					
Male		Female to Male (FTM) / Transgender Male / Trans Man		Genderqueer, neither exclusivley male nor female	
Female		Male to Female (MTF) / Transgender Female/ Trans Women		Choose not to disclose	
Sexual Orientation:					
Lesbian, gay or homosexual		Straight or heterosexual		Bisexual	
Do not know		Choose not to disclose		Something else, please describe:	

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: Home Cell Work			

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Emergency Contact:

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

Family Medical History:

Relation:	Age:	Seizure/Epilepsy History?	Other Health Issues:	Deceased?	Cause of Death:
Mother:					
Father:					
Sisters:					
Brothers:					
Maternal Grandmother:					
Maternal Grandfather:					
Paternal Grandmother:					
Paternal Grandfather:					
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 is not applicable)

Electroencephalogram (EEG) History

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

CAT (CT) Scan History- Please complete for most recent CT if applicable.

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

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Magnetic Resource Imaging (MRI) History- Please complete for the most recent MRI if applicable.

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

<u>Hospitalizations/Emergency Room Visits in the past year:</u>

Number of seizure related: ______________________

Number of other medical: _______________________ Reasoning: _________________________

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

Number of emergency room visits in the last 12 months: _________________________

List of most pertinent hospitalizations if any:

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

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

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Education

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

Is the patient driving? Yes No

Seizure History:

Age of first seizure: ____________________ Date of first seizure: ____________________

Circumstance 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: ____

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Have seizures interfere with patient's life and goals? If so, how? ______________________________
____
____
____
____

Does anything seem to trigger the patient's seizures? ______________________________________
____
____
____

Medications:

Current anti-epileptic medications (AED)

Drug Name: *Example: Keppra*	Dose: *Example: 1000mg*	Times medication is 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 is taken:

Are any of the patient's medications to be taken at school?_______________________________

Does patient take medications independently?_______________________________________

Allergies (medication name or other known allergies and reactions):_________________________

____

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____

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MN EpilepsyGroup

Focused expertise. Comprehensive care.

Developmental History

Pregnancy and Birth:

Duration of pregnancy: _______ weeks (i.e. 35 weeks)

Were there any complications with pregnancy? *(i.e. UTI, accident, seizures, substance abuse, bleeding, diabetes, etc.)* Please List:____

____

Delivery: Natural Induced C-Section

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

____

APGAR score if known (this is a test given after birth assessing heart rate, muscle tone, and other signs to see if medical care or emergency care is needed):

______________@ 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 concern 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 a fork, color inside lines.	Concerns:
Language Skills:	Examples: Coos, says single word, says complete sentences, reading, understands simple commands, tells time.	Concerns:

Alternative Communication

If the patient does not communicate verbally are they able to communication with:

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: ______________________________

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Any other information you would like us to know? ______________________________

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

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