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EPILEPSY

Today's Date

Last Name First MI

Date of Birth Age

GENERAL PATIENT INFORMATION

You must complete or already have on file the ***patient medical history short form*** or ***long form***.
Please make sure that all of the information on your medical history form is updated including phone numbers, addresses and insurance information.

Answer the following questions and bring the answers to your appointment.

PRESENT ILLNESS - EPILEPSY

How long have you had seizures?

Do you have any of the following risk factors for seizures?

- ☐ Birth injury
- ☐ Febrile seizure
- ☐ Prior neurosurgery
- ☐ Head injury
- ☐ Stroke

Indicate the type of seizures and the frequency (number of seizures per week):

- ☐ Simple Partial /week
- ☐ Complex Partial /week
- ☐ Generalized Tonic Clonic (grand mal) /week
- ☐ Myoclonic (jerks) /week
- ☐ Absence (staring spells) /week
- ☐ Atonic (drop seizures) /week
- ☐ Tonic (stiffening seizures) /week
- ☐ Any other type /week

Describe:

Can you tell if you are about to have a seizure? ☐ Yes ☐ No

If YES, please explain:

MEDICATIONS

What are your current medications, include hormones, birth control pills, vitamins, etc. (Name and amount/day)?

Medication	Amount	Medication	Amount
1		6	
2		7	
3		8	
4		9	
5		10	

List all seizure medications you have previously tried:

List any side effects to previous seizure medications:

List any allergies to medications:

Are you taking oral contraceptive pills? ☐ Yes ☐ No If YES, how long?

Do you take any herbal supplements? ☐ Yes ☐ No

PAST MEDICAL HISTORY, REVIEW OF SYSTEMS

Check health issues you currently have or have had in the past:

General Health Problems

☐ Abdominal Pain	☐ Back Pain	☐ Blurred vision
☐ Change in vision	☐ Chest pain	☐ Constipation
☐ Diarrhea	☐ Diabetes	☐ Dizziness
☐ Double vision	☐ Easy fatigue	☐ Headaches
☐ Hearing problems	☐ Heart problems	☐ High cholesterol
☐ High or low blood pressure	☐ Leg swelling	☐ Loss of appetite
☐ Loss of vision	☐ Migraine or other headaches	☐ Muscle cramps

- [ ] Muscle wasting
- [ ] Nausea
- [ ] Neck Pain
- [ ] Palpitations (abnormal or fast beating of the heart)
- [ ] Pain in back of jaw (TMJ)
- [ ] Shortness of breath
- [ ] Stomach Pain
- [ ] Vomiting
- [ ] Weakness
- [ ] Weight gain/loss
- [ ] Other pain, location or type:

Psychological Problems

- [ ] Treatment by a psychiatrist or counselor
- [ ] Depression or unusual amounts of stress
- [ ] Panic Attacks

Cancer

- [ ] What type:
- [ ] 15 lb or more weight loss

Systemic Diseases

- [ ] AIDS

Metabolic Problems

- [ ] Arthritis
- [ ] Kidney problems
- [ ] Blood diseases, anemia
- [ ] Dialysis
- [ ] Liver disease
- [ ] Fevers or swollen glands
- [ ] Low sugar (hypoglycemia)
- [ ] Skin diseases
- [ ] Thyroid disorders
- [ ] Lupus
- [ ] Syphilis or venereal disease
- [ ] Mononucleosis (Epstein Barr)
- [ ] Lyme disease
- [ ] Meningitis
- [ ] Tuberculosis (TB)

Eye Problems

- [ ] Crossed eyes, lazy eye
- [ ] Poor vision in one eye (amblyopia)

Neurological Problems

- [ ] Bladder problems
- [ ] Tremor or incoordination
- [ ] Problems with sexual function
- [ ] Trouble speaking
- [ ] Loss of consciousness (faints or seizures)

☐ Pins and needles, numbness (where)

☐ Muscle weakness (where)

Surgeries

☐ Appendix ☐ Breast ☐ Cataract ☐ Carotid

☐ C-Section ☐ Ear ☐ Gall Bladder ☐ Hysterectomy

☐ Prostate ☐ Sinus ☐ Stomach ☐ Tonsils

☐ Other:

LIFE STYLE - HABITS

Educational level completed:

☐ Grade school ☐ High school ☐ College ☐ Post graduate

Are you currently receiving disability? ☐ Yes ☐ No If YES, how long?

Living arrangements:

☐ Live alone ☐ With spouse or roommate ☐ With parents ☐ Other:

Have you ever had a car accident? ☐ Yes ☐ No

If YES, please explain:

How many alcoholic drinks per week? ☐ None ☐

Do you smoke cigarettes, cigars or pipes ? ☐ No ☐ Yes

How many caffeinated drinks per day? ☐ None ☐ More than 4

Do you have regular sleep/wake patterns ? ☐ No ☐ Yes

Do you salt your food? ☐ No ☐ Moderate ☐ Lots

Are you currently involved in litigation with respect to any medical problems ? ☐ No ☐ Yes

Are you usually highly stressed? ☐ No ☐ Yes

Do you usually eat 3 meals/day? ☐ No ☐ Yes

INJURIES (Check and date)

☐ Head date

☐ Neck (for example whiplash) date

☐ Dental work date

EXPOSURES OR INFECTIONS: (Check and date)

- ☐ Carbon Monoxide (car or house) date
- ☐ Tuberculosis or Cysticercosis date
- ☐ History of meningitis date

FAMILY HISTORY

Are there any **family members** with:

- ☐ Stroke
- ☐ Diabetes
- ☐ Seizures
- ☐ Heart disease or high blood pressure
- ☐ Migraine headaches
- ☐ Other diseases that run in the family (list)

GENERAL MEDICAL TESTS

- ☐ Recent general medical checkup? Date:
- ☐ Recent blood tests (Glucose, blood count) Date:
- ☐ Heart test (EKG, Stress test, Holter Monitor) Date:

SLEEP PROBLEMS – THE EPWORTH SLEEPINESS SCALE

How likely are you to *doze off or fall asleep,* in contrast to just feeling tired, in the following situations? This refers to your usual way of life in recent times. Even if you have not done a particular activity recently, try to work out how they would have affected you. Check your chance of dozing or falling asleep as: would never doze, slight chance of dozing, moderate chance of dozing, high chance of dozing or falling asleep.

Sitting and reading	☐ 0-Never	☐ 1-Slight	☐ 2-Moderate	☐ 3-High
Watching television	☐ 0-Never	☐ 1-Slight	☐ 2-Moderate	☐ 3-High
Sitting inactive in a public place (e.g. theater)	☐ 0-Never	☐ 1-Slight	☐ 2-Moderate	☐ 3-High
As a passenger in a car for an hour	☐ 0-Never	☐ 1-Slight	☐ 2-Moderate	☐ 3-High
Lying down to rest in the afternoon	☐ 0-Never	☐ 1-Slight	☐ 2-Moderate	☐ 3-High
Sitting and talking to someone	☐ 0-Never	☐ 1-Slight	☐ 2-Moderate	☐ 3-High
Sitting quietly after lunch without alcohol	☐ 0-Never	☐ 1-Slight	☐ 2-Moderate	☐ 3-High
In a car, stopped in traffic	☐ 0-Never	☐ 1-Slight	☐ 2-Moderate	☐ 3-High

Total Points:

Answer the following as: Never, Sometimes, Often, Always

Do you fall asleep or get sleepy when driving?	☐ 0-Never	☐ 1-Some	☐ 2-Often	☐ 3-Always
Do you fall asleep or get sleepy when at work?	☐ 0-Never	☐ 1-Some	☐ 2-Often	☐ 3-Always
Do you take intentional naps?	☐ 0-Never	☐ 1-Some	☐ 2-Often	☐ 3-Always
Do you experience short periods of muscle weakness or loss of muscle control (especially with laughter or excitement)?	☐ 0-Never	☐ 1-Some	☐ 2-Often	☐ 3-Always
Do you experience vivid dreamlike episodes when falling asleep?	☐ 0-Never	☐ 1-Some	☐ 2-Often	☐ 3-Always
Do you feel unable to move (paralyzed) when falling asleep?	☐ 0-Never	☐ 1-Some	☐ 2-Often	☐ 3-Always
Do you ever experience an uncomfortable or restless sensation in your legs when you relax or are first going to sleep, that is relieved by moving or getting out of bed and walking?	☐ 0-Never	☐ 1-Some	☐ 2-Often	☐ 3-Always

Total Points: