MINCEP® Epilepsy Care
University of Minnesota Physicians

Patient Name _____

Date _____

New Patient Questionnaire

I - INTRODUCTION

Please tell us about your medical condition by answering the questions on the following pages. **This is important**. Be as complete as you can be. If you have any questions, please contact us at (952) 525-4500 for assistance. If you need additional space, please attach additional page(s) and write in the number of the question you are answering. Please note, some questions may not apply due to age or gender.

Name of person completing this form and relationship to patient: _____

1. Will anyone be attending the appointment with you? ☐ Yes ☐ No
   If yes, list their name and relationship to you: _____ _____
   _____ _____

2. Do you have a legal guardian? ☐ Yes ☐ No If yes, list their name and relationship to you:
   Name _____ Relationship _____
   Address _____ Telephone _____
   City _____ Email address _____
   State _____ Zip _____

3. How did you hear about MINCEP® Epilepsy Care?

Health Care	☐ Fam/Gen Practioner ☐ Neurologist ☐ Social Worker/Agency ☐ Other _____
Non-Health Care	☐ Relative/Friend ☐ Teacher/School ☐ Patient ☐ Other _____
MINCEP Employee	☐ Physician ☐ Non-Physician
MINCEP Event	☐ Consumer Seminar ☐ Speaking Engagement ☐ Other _____
Marketing Material	☐ MINCEP's Publication/Brochure ☐ Direct Mailing ☐ Other _____
Internet/Web Page	☐ MINCEP's Web Page ☐ Other's Web Page (Name) _____
Advertising	☐ Newspaper ☐ TV ☐ Radio ☐ Magazine ☐ Yellow Pages ☐ Other _____
Consumer Event	☐ EFM ☐ EFA ☐ Women's EXPO ☐ Other _____
Professional Event	☐ AAN ☐ AES ☐ Other _____
Referral System	☐ Insurance Referral ☐ Provider Directory ☐ NAEC ☐ EFM ☐ Other _____
Other	_____

4. Age_____ Gender ☐ M ☐ F Handedness ☐ Right-handed ☐ Left-handed ☐ Use both hands

5. What do you hope to accomplish during your evaluation at MINCEP® Epilepsy Care?
   _____
   _____
   _____
   _____
   _____

6. Name and address of the physician currently providing prescriptions and refills for your seizure medication.
   Name _____ Specialty _____
   Clinic _____ Telephone _____
   Address _____
   City _____ State _____ Zip _____
   Dates of Care _____ Have you requested these records? ☐ Yes ☐ No

7. Name and address of the physician and/or clinic to whom to send the results of this evaluation.

Name _____ Specialty _____

Clinic _____ Telephone _____

Address _____

City _____ State _____ Zip _____

Dates of Care _____

II - PAST MEDICAL RECORDS

List the physicians who have treated you for seizures in the last ten years. Include first and last names of doctors, center or clinic names, complete addresses (including zip codes) and telephone numbers. We have enclosed release of information forms that will give these doctors permission to send us your records. Please complete a release for each doctor, hospital or testing site and ask them to send us your records prior to your appointment (or you may pick up your records and bring them to MINCEP®).

8. Physician Information: (most recent first): (attach additional sheets if needed)

Name _____ _____ Specialty _____

Clinic _____

Address _____

City _____ State _____ Zip _____

Phone # _____ Dates of Care _____

Name _____ _____ Specialty _____

Clinic _____

Address _____

City _____ State _____ Zip _____

Phone # _____ Dates of Care _____

Name _____ _____ Specialty _____

Clinic _____

Address _____

City _____ State _____ Zip _____

Phone # _____ Dates of Care _____

9. Hospital Information: (attach additional sheets if needed)

Name _____

Address _____

City _____ State _____ Zip _____

Phone # _____ Dates of Care _____

Reason for Hospitalization: _____

Name _____

Address _____

City _____ State _____ Zip _____

Phone # _____ Dates of Care _____

Reason for Hospitalization: _____

III - SEIZURE INFORMATION

10. Date of first seizure: _____ Age at time of first seizure: _____

11. Describe your first seizure. What were the circumstances? What was the seizure like?

_____

_____

_____

_____

12. Describe how your seizures have changed (in severity, frequency, warning signs, seizure types) over the years.

_____

_____

_____

_____

13. Since you began having seizures, what is the longest period of time you have been seizure-free?

_____

_____

INSTRUCTIONS FOR DESCRIBING SEIZURES:

14. Please describe what your seizures are like. You may need to gather this information from those who have observed your seizures.
    a. 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.
    b. Include the following information in your descriptions:
        - Is there a warning? What is it like?
        - How does the seizure begin?
        - What do you do during the seizure? (Describe what is felt and what the body does.)
        - Do you remember events that occur during the seizure?
        - What is your behavior after a seizure?
    c. If you have difficulty in describing the seizure, just provide as much information as possible. A member of the MINCEP medical staff will go over the descriptions during the initial appointment.

Seizure Type #1 _____

_____

_____

_____

_____

Loss of Contact with the World: ☐ Yes ☐ No ☐ Partial
Warning or Aura: ☐ Always or almost always ☐ Sometimes ☐ Never
Length of Seizure: _____
Approximate Seizure Frequency*: _____
*If frequency is fewer than one per year, what is the total number of this type of seizure:_____

Seizure Type #2 _____

_____

_____

_____

_____

Loss of Contact with the World: ☐ Yes ☐ No ☐ Partial
Warning or Aura: ☐ Always or almost always ☐ Sometimes ☐ Never
Length of Seizure: _____
Approximate Seizure Frequency*: _____
*If frequency is fewer than one per year, what is the total number of this type of seizure:_____

Seizure Type #3 _____

_____

_____

_____

_____

Loss of Contact with the World: ☐ Yes ☐ No ☐ Partial
Warning or Aura: ☐ Always or almost always ☐ Sometimes ☐ Never
Length of Seizure: _____
Approximate Seizure Frequency*: _____
*If frequency is fewer than one per year, what is the total number of this type of seizure: _____

15. The following questions refer to your epilepsy in general. Please do not consider auras when answering these questions. Please refer to the past six months when answering these questions.

How often do you fall to the ground during your seizures? ☐ Very often (more than 75% of the time)
☐ Often (25 - 75% of the time) ☐ Occasionally (less than 25% of the time) ☐ Never

How often do you have convulsions with your seizures? ☐ Very often (more than 75% of the time)
☐ Often (25 - 75% of the time) ☐ Occasionally (less than 25% of the time) ☐ Never

Have your seizures caused any of the following? ☐ Burns, Scalds, Deep Cuts, Fractures
☐ Bitten Tongue, Severe Headaches ☐ Milder Injuries, Mild Headache ☐ No Injuries, No Headaches

How often do you become incontinent of urine during your seizures? ☐ Very often (more than 75% the time)
☐ Often (25 - 75% of the time) ☐ Occasionally (less than 25% of the time) ☐ Never

If your seizures cause loss of consciousness, is there a warning long enough for you to protect yourself?
☐ Never ☐ Sometimes ☐ Always or nearly always ☐ No loss of consciousness or seizures occur during sleep

How long is it before you are really back to normal after your seizures, on average? ☐ Less than 1 minute
☐ 1 minute to 10 minutes ☐ 10 minutes to 60 minutes ☐ 1 to 3 hours ☐ Longer than 3 hours

Do the following occur with your seizures?
☐ Serious disruptive automatic activity such as shouting, wandering, undressing, touching others
☐ Mild automatic activity such as lip smacking, plucking at clothing, one sided jerking
☐ None

16. Do any of these factors bring on your seizures? (Check the ones that apply.)

☐ No clear precipitating factors	☐ Ovulation	☐ Exercise	☐ Alcohol withdrawal
☐ Startle	☐ Failure to take medications	☐ Hyperventilation	☐ Using illegal drugs
☐ Emotional stress	☐ Taking other medications	☐ Breath holding	☐ Television
☐ Fatigue	☐ Illness	☐ Reading	☐ Computer screens
☐ Lack of sleep	☐ Fever	☐ Sounds	☐ Video games
☐ Foods	☐ Pain	☐ Lights	☐ Don't know
☐ Change in eating habits	☐ Vomiting	☐ School	Other
☐ Known low blood sugar	☐ Diarrhea	☐ Sex	_____
☐ Menstruation (periods)	☐ Constipation	☐ Alcohol consumption	_____

17. Have you ever had continuous seizure activity for which you had to seek medical attention?
☐ Yes ☐ No ☐ Unknown If yes, how were seizures stopped? _____
_____

18. Have you had any inpatient hospitalizations related to seizures in the past 12 months?
☐ Yes ☐ No ☐ Unknown If yes, how many? _____

19. Have you had any emergency room visits related to seizures in the past 12 months?
☐ Yes ☐ No ☐ Unknown If yes, how many? _____

IV - RELATED HISTORY - RISK FACTORS FOR EPILEPSY

20. Do you know the cause of your seizures? ☐ Yes ☐ No If yes, describe:

_____

_____

21. Have you ever been told that your epilepsy is inherited? ☐ Yes ☐ No If yes, describe:

_____

_____

22. Do any of your family members have epilepsy or seizures? ☐ Yes ☐ No ☐ Unknown
If yes, relation to you: _____

23. Did your mother have any medical problems while she was pregnant with you? ☐ Yes ☐ No ☐ Unknown
If yes, describe: _____

_____

24. Are you a twin (or other multiple)? ☐ Yes ☐ No

25. What was your birth weight? _____ Pounds _____ Ounces

26. Did you have any delays in development? (e.g. walking, talking, etc.) ☐ Yes ☐ No ☐ Unknown

27. Have you ever had seizures related to fever? ☐ Yes ☐ No ☐ Unknown
If yes at what age: _____ How many? _____

28. Have you had encephalitis or meningitis? ☐ Yes ☐ No

29. Have you ever had a head injury that you received treatment for? ☐ Yes ☐ No ☐ Unknown

30. Have you ever been diagnosed with a brain tumor? ☐ Yes ☐ No
If yes, date of diagnosis: _____
Was surgery performed? ☐ Yes ☐ No If yes, when: _____

31. Have you ever had a stroke or bleeding in the brain? ☐ Yes ☐ No

V - PREVIOUS TESTING FOR EPILEPSY

32. Please provide information about the following tests. If you need more space please list on the back.

Have you had?		How many?	Date of Most Recent	Location of procedure including address
Routine EEG	☐ Yes ☐ No ☐ Not Sure	_____	_____	_____
Video EEG Monitoring	☐ Yes ☐ No ☐ Not Sure	_____	_____	_____
CAT/CT scan	☐ Yes ☐ No ☐ Not Sure	_____	_____	_____
MRI (Magnetic Resonance Imaging)	☐ Yes ☐ No ☐ Not Sure	_____	_____	_____

Have you had?		How many?	Date of Most Recent	Location of procedure including address
PET / SPECT	☐ Yes ☐ No ☐ Not Sure			
Neuropsychological or Psychological Testing	☐ Yes ☐ No ☐ Not Sure			

33. Have you had problems with any testing or needed sedation during testing? ☐ Yes ☐ No
If yes, please explain: _____

34. Have you ever had an allergic reaction to x-ray dyes? ☐ Yes ☐ No ☐ Unknown
If yes, describe _____

VI - MEDICATION & OTHER TREATMENT HISTORY

35. List **all** current medications you are taking (seizure medications first, then others):

Drug Name	Size of Tablet (in mg per tablet)	Dosage Times	Total Daily Amt. (in milligrams)	Generic
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

36. Are you currently taking:
Multi-Vitamin ☐Yes ☐No
Vitamin D ☐Yes ☐No
Calcium ☐Yes ☐No
Folic Acid ☐Yes ☐No
Birth Control Prescribed by Physician: ☐Yes ☐No Type: _____

37. Complementary or alternative medicine (example herbal): _____

38. Have you ever been treated with the following medications for seizures? Circle medication name (brand or generic). If unknown, indicate in comments:

Brand Name	Generic Name	Yes / No	Comments / Reason discontinued
Ativan	(lorazepam)	☐Yes ☐No	
Carbatrol	(carbamazepine)	☐Yes ☐No	
Depakene	(valproic acid)	☐Yes ☐No	
Depakote	(divalproex sodium)	☐Yes ☐No	
Depakote ER		☐Yes ☐No	
Diastat	(diazepam rect)	☐Yes ☐No	
Dilantin	(phenytoin)	☐Yes ☐No	

Brand Name	Generic Name	Yes / No	Comments / Reason discontinued
Felbatol	(felbamate)	☐Yes ☐No	
Gabitril	(tiagabine)	☐Yes ☐No	
Banzel	(rufinamide)	☐Yes ☐No	
Keppra	(levetiracetam)	☐Yes ☐No	
Klonopin	(clonazepam)	☐Yes ☐No	
Lamictal	(lamotrigine)	☐Yes ☐No	
Lyrica	(pregabalin)	☐Yes ☐No	
Mysoline	(primidone)	☐Yes ☐No	
Neurontin	(gabapentin)	☐Yes ☐No	
Phenobarbital		☐Yes ☐No	
Tegretol	(carbamazepine)	☐Yes ☐No	
Tegretol XR		☐Yes ☐No	
Topamax	(topiramate)	☐Yes ☐No	
Trileptal	(oxcarbazepine)	☐Yes ☐No	
Valium	(diazepam)	☐Yes ☐No	
Vimpat	(lacosamide)	☐Yes ☐No	
Zarontin	(ethosuximide)	☐Yes ☐No	
Zonegran	(zonisamide)	☐Yes ☐No	
Other: _____			

39. Are you allergic to any medications? ☐ Yes ☐ No If yes, please describe:

Drug Name	Reaction (rash, difficulty breathing, etc.)

40. Are you currently experiencing any side effects? ☐ Yes ☐ No If yes, please describe:

41. Do you take your medications independently? ☐ Yes ☐ No

42. Do you use a pillbox? ☐ Yes ☐ No If yes, what type is it? ☐ Daily ☐ Weekly ☐ Other _____

43. How often do you miss your medications?
☐ Never ☐ Rarely ☐ Occasionally ☐ Frequently ☐ Other _____

44. Have you had surgical treatment for your epilepsy? ☐ Yes ☐ No

If yes, please indicate what type:	Date	Hospital
Brain Surgery		
Vagus Nerve Stimulator (VNS)		
Deep Brain Stimulator (DBS)		
Other:		

45. Have you ever been treated for seizures with any of the following? If yes, describe who treated you and when the treatment occurred.

Ketogenic Diet	☐ Yes	☐ No	
Acupuncture	☐ Yes	☐ No	
Homeopathic Medicines	☐ Yes	☐ No	
Hypnosis	☐ Yes	☐ No	
Meditation	☐ Yes	☐ No	
Other Healing Methods	☐ Yes	☐ No	

VII - MEDICAL PROBLEMS OTHER THAN EPILEPSY

46. Do you or have you had any other chronic illnesses or serious medical problems?
(for example: diabetes, high blood pressure, heart problems) ☐ Yes ☐ No If yes, describe:

47. Have you had any other previous hospitalizations? ☐ Yes ☐ No If yes, describe:

48. Have you ever had surgery? ☐ Yes ☐ No If yes, list type, dates and your age at the time of surgery:

Surgery Type	Date of Surgery	Age
For Women: Tubal ligation		
Hysterectomy		
Oophorectomy		

49. Are you scheduled for any surgery? ☐ Yes ☐ No If yes, list when & type of surgery:

VIII - FAMILY MEDICAL HISTORY

50. Do any of your family members have any of the following health problems:

				Relation:
Migraine Headaches	☐ Yes	☐ No	☐ Unknown	
Cancer	☐ Yes	☐ No	☐ Unknown	
Heart Disease	☐ Yes	☐ No	☐ Unknown	
Diabetes	☐ Yes	☐ No	☐ Unknown	
High Blood Pressure	☐ Yes	☐ No	☐ Unknown	
Strokes/Heart Attacks	☐ Yes	☐ No	☐ Unknown	
Depression or Suicide	☐ Yes	☐ No	☐ Unknown	
Sudden Death Under Age 40	☐ Yes	☐ No	☐ Unknown	
Hip Fracture in Parents	☐ Yes	☐ No	☐ Unknown	

Other:

IX - SOCIAL/EDUCATIONAL/VOCATIONAL HISTORY

51. Describe your childhood including your early childhood: _____

52. Did you experience any serious physical or emotional trauma during your childhood or adolescence? ☐ Yes ☐ No
If yes, Near death? ☐ Yes ☐ No
Physical or sexual abuse? ☐ Yes ☐ No
Other: _____

53. What type of education did you receive?
☐ None ☐ Special Education ☐ Home Schooling
☐ Regular Classes ☐ Other _____

54. What is the highest level of education that you have completed?
☐ Grade School ☐ Middle School ☐ High School ☐ GED ☐ Vo-Tech ☐ Business School
☐ Associate's Degree ☐ Bachelor's Degree ☐ Master's Degree ☐ Doctoral Degree
Post secondary education in: _____

55. Are you currently a student? ☐ Yes ☐ No If yes, current level: _____
Area of study: _____ School/College name and location _____

56. What is your current occupation? _____
Employer Name _____ Number of years at job: _____

57. What type(s) of previous employment have you had?
_____ Number of years at job: _____
_____ Number of years at job: _____

59. What is your marital status? ☐ Does not apply (child) ☐ Never married ☐ Married
☐ Separated ☐ Divorced ☐ Widowed

60. Number of Children: _____ Age(s) of Children: _____

61. Have you experienced any major life changing events in the last few years?
(for example: birth of child, marriage, divorce, job change, move, death in family) ☐ Yes ☐ No If yes, describe:

62. How satisfied are you with the following aspects of your **present life situation**? (For each item, check the response which most closely reflects how you feel.)

Seizure Control	☐ Very Dissatisfied	☐ Somewhat Dissatisfied	☐ Somewhat Satisfied	☐ Very Satisfied
Employment	☐ Very Dissatisfied	☐ Somewhat Dissatisfied	☐ Somewhat Satisfied	☐ Very Satisfied
Education	☐ Very Dissatisfied	☐ Somewhat Dissatisfied	☐ Somewhat Satisfied	☐ Very Satisfied
Finances	☐ Very Dissatisfied	☐ Somewhat Dissatisfied	☐ Somewhat Satisfied	☐ Very Satisfied
Living Arrangement	☐ Very Dissatisfied	☐ Somewhat Dissatisfied	☐ Somewhat Satisfied	☐ Very Satisfied
Social Life	☐ Very Dissatisfied	☐ Somewhat Dissatisfied	☐ Somewhat Satisfied	☐ Very Satisfied
Sex Life	☐ Very Dissatisfied	☐ Somewhat Dissatisfied	☐ Somewhat Satisfied	☐ Very Satisfied

63. What is your current use of the following substances (in the last 6 months)?

Alcohol	How many days per week do you drink alcohol on average?	_____
	How many drinks do you have on a typical day?	_____
	Maximum drinks on a single occasion in the past month?	_____
	Have you drunk alcohol more than you intended during this period?	☐ Yes ☐ No
	Have you ever felt the need to cut down your drinking?	☐ Yes ☐ No
Tobacco	☐ Never ☐ Less than 1 pack a day ☐ 1 or more packs a day	
Caffeine	☐ Never ☐ Less than 4 servings per day ☐ 4 or more servings per day	
	Check type: ☐ Coffee ☐ Tea ☐ Pop ☐ Energy drinks ☐ Other _____	
Marijuana	☐ Never ☐ Occasionally ☐ Daily	
Other	_____	
	Usual amount and frequency _____	

64. Do you have a history of chemical dependency? ☐ Yes ☐ No

If yes, when usage stopped: _____

Describe dependency: _____

X - PSYCHOLOGICAL HISTORY

65. Have you ever completed any psychological evaluations? ☐ Yes ☐ No

66. Have you ever been seen by a psychiatrist or for psychological counseling? ☐ Yes ☐ No

67. If yes:

Name _____ _____ Specialty _____

Clinic _____

Address _____

City, State, Zip _____ _____ _____

Telephone _____ Dates of Care _____

Name _____ _____ Specialty _____

Clinic _____

Address _____

City, State, Zip _____ _____ _____

Telephone _____ Dates of Care _____

68. Are you being treated with medication for depression or anxiety? ☐ Yes ☐ No

69. In the last month:

Have you felt depressed, sad or blue much of the time? ☐ Yes ☐ No

Have you often felt helpless about the future? ☐ Yes ☐ No

Have you had little interest or pleasure in doing things? ☐ Yes ☐ No

Have you had trouble sleeping many nights? ☐ Yes ☐ No

70. How has having seizures affected what you think of yourself?

_____

_____

_____

_____

_____

_____

71. Take a few minutes to describe yourself, your personality, and your family. Enclose a picture of yourself if you would like. Also, have your seizures interfered with your life? If so, how? Has your personality changed since the onset of seizures?

_____

_____

_____

_____

72. Many people find that spirituality is an important part of overcoming the negative aspects of a chronic disease. If you wish, share the following information with us along with any questions or comments:

Religious Denomination (if any): _____

Meditation Techniques (if any): _____

_____

_____

XI - REVIEW OF SYSTEMS

73. Do you have any food, environmental, or other allergies? ☐ Yes ☐ No If yes, describe:

_____

_____

74. In the past few months, have you had any of the following?

GENERAL	☐ fever ☐ significant weight gain ☐ significant weight loss
EYES	☐ double vision ☐ blurred vision ☐ discharge ☐ loss of vision
EARS	☐ decreased hearing ☐ pain ☐ hearing aid ☐ ringing ☐ dizziness
NOSE	☐ bleeding ☐ discharge
THROAT	☐ gum problems ☐ hoarseness ☐ trouble swallowing ☐ pain
HEART	☐ chest pains ☐ swelling of legs ☐ palpitations
LUNG	☐ trouble breathing ☐ shortness of breath with exercise ☐ chronic cough ☐ shortness of breath at rest ☐ coughing up blood or mucus
STOMACH & INTESTINE	☐ nausea ☐ abdominal pain ☐ diarrhea ☐ abnormal stool color ☐ vomiting ☐ loss of appetite ☐ constipation ☐ incontinence of stool
GENITOURINARY	☐ painful urination ☐ urinary incontinence ☐ urine retention ☐ blood in urine ☐ frequent urination ☐ sexual difficulties
MUSCLE	☐ weakness ☐ tremors ☐ stiffness ☐ limited movement
SKIN	☐ rashes ☐ itching ☐ lumps ☐ flaking ☐ easy bruising or bleeding ☐ birthmark
NEURO	☐ headaches ☐ tingling ☐ memory loss ☐ weakness on one side of body ☐ confusion ☐ sleep problems ☐ loss of balance ☐ weakness in general

75. Bone Health and Falls (check all that apply):

☐ Falls not due to seizures in the last 3 months ☐ Falls not due to seizures in the last 12 months

☐ Routinely take multivitamins ☐ Routinely take a calcium supplement

☐ Fractures If yes, how many & when: _____

_____

☐ Walk or run for exercise ☐ Need a cane, walker or other aid to help you walk

☐ Outside in the sun for greater than 45 minutes per week when weather allows

76. **FOR WOMEN:**

At what age did you start menstruating? _____ Date of your last period: _____

What is your usual cycle (in days)? _____ Are your cycles regular? ☐ Yes ☐ No

Are you sexually active? ☐ Yes ☐ No

What kind of birth control method are you using (if any)? _____

Have you experienced any problems with the birth control method(s) you use / have used? ☐ Yes ☐ No

_____

Are you currently pregnant? ☐ Yes ☐ No If yes, what is the due date? _____

Are you planning to become pregnant? ☐ Yes ☐ No If yes, when? _____

How many biological children do you have? _____

Have you had any miscarriages? ☐ Yes ☐ No If yes, how many? _____

any premature deliveries? ☐ Yes ☐ No If yes, how many? _____

any birth defects? ☐ Yes ☐ No If yes, how many? _____

What is your current stage of menopause?

- ☐ Have not begun
- ☐ Unsure if begun
- ☐ Currently experiencing
- ☐ Post menopause

Are you on hormonal replacement therapy? ☐ Yes ☐ No If yes, what kind? _____

Thank you for taking the time to fill out this Questionnaire!

For Office Use only:

1. *Epilepsy Syndrome and Syndrome Status*
2. *Etiology*
3. *Seizure Types*
4. *Epilepsy Status*
5. *Impression*
6. *Plan*