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 __________________________ Email address _________
   City __________________________ State ______ Zip __________

3. How did you hear about MINCEP® Epilepsy Care?
   Health Care □ Fam/Gen Practitioner □ 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 □ EF M □ 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

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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)

<table>
<thead>
<tr>
<th>Name</th>
<th>Specialty</th>
<th>Phone #</th>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic</td>
<td></td>
<td></td>
<td>Clinic Address</td>
<td>City</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>Phone #</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic</td>
<td></td>
<td></td>
<td>Clinic</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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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: _________________
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)  
- 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)  
- 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% 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?  
- No loss of consciousness or seizures occur during sleep  
- Sometimes  
- Never  
- Always or nearly always

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?  
- Serous 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  
- Alcohol consumption  
- 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.  

<table>
<thead>
<tr>
<th>Have you had?</th>
<th>How many?</th>
<th>Date of Most Recent</th>
<th>Location of procedure including address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine EEG</td>
<td>□ Yes □ No □ Not Sure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Video EEG Monitoring</td>
<td>□ Yes □ No □ Not Sure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CAT/CT scan</td>
<td>□ Yes □ No □ Not Sure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MRI (Magnetic Resonance Imaging)</td>
<td>□ Yes □ No □ Not Sure</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### VI - MEDICATION & OTHER TREATMENT HISTORY

#### 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 ________________________________________________________________

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

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Size of Tablet (in mg per tablet)</th>
<th>Dosage Times</th>
<th>Total Daily Amt. (in milligrams)</th>
<th>Generic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ativan</td>
<td></td>
<td></td>
<td></td>
<td><img src="/checkmark" alt="Yes" /> <img src="/checkmark" alt="No" /></td>
</tr>
<tr>
<td>Carbatrol</td>
<td></td>
<td></td>
<td></td>
<td><img src="/checkmark" alt="Yes" /> <img src="/checkmark" alt="No" /></td>
</tr>
<tr>
<td>Depakene</td>
<td></td>
<td></td>
<td></td>
<td><img src="/checkmark" alt="Yes" /> <img src="/checkmark" alt="No" /></td>
</tr>
<tr>
<td>Depakote</td>
<td></td>
<td></td>
<td></td>
<td><img src="/checkmark" alt="Yes" /> <img src="/checkmark" alt="No" /></td>
</tr>
<tr>
<td>Depakote ER</td>
<td></td>
<td></td>
<td></td>
<td><img src="/checkmark" alt="Yes" /> <img src="/checkmark" alt="No" /></td>
</tr>
<tr>
<td>Diastat</td>
<td></td>
<td></td>
<td></td>
<td><img src="/checkmark" alt="Yes" /> <img src="/checkmark" alt="No" /></td>
</tr>
<tr>
<td>Dilantin</td>
<td></td>
<td></td>
<td></td>
<td><img src="/checkmark" alt="Yes" /> <img src="/checkmark" alt="No" /></td>
</tr>
</tbody>
</table>

#### 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:

<table>
<thead>
<tr>
<th>Brand Name</th>
<th>Generic Name</th>
<th>Yes / No</th>
<th>Comments / Reason discontinued</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ativan</td>
<td>lorazepam</td>
<td><img src="/checkmark" alt="Yes" /> <img src="/checkmark" alt="No" /></td>
<td>______________________________</td>
</tr>
<tr>
<td>Carbatrol</td>
<td>carbamazepine</td>
<td><img src="/checkmark" alt="Yes" /> <img src="/checkmark" alt="No" /></td>
<td>______________________________</td>
</tr>
<tr>
<td>Depakene</td>
<td>valproic acid</td>
<td><img src="/checkmark" alt="Yes" /> <img src="/checkmark" alt="No" /></td>
<td>______________________________</td>
</tr>
<tr>
<td>Depakote</td>
<td>divalproex sodium</td>
<td><img src="/checkmark" alt="Yes" /> <img src="/checkmark" alt="No" /></td>
<td>______________________________</td>
</tr>
<tr>
<td>Depakote ER</td>
<td></td>
<td><img src="/checkmark" alt="Yes" /> <img src="/checkmark" alt="No" /></td>
<td>______________________________</td>
</tr>
<tr>
<td>Diastat</td>
<td>diazepam rect</td>
<td><img src="/checkmark" alt="Yes" /> <img src="/checkmark" alt="No" /></td>
<td>______________________________</td>
</tr>
<tr>
<td>Dilantin</td>
<td>phenytoin</td>
<td><img src="/checkmark" alt="Yes" /> <img src="/checkmark" alt="No" /></td>
<td>______________________________</td>
</tr>
<tr>
<td>Brand Name</td>
<td>Generic Name</td>
<td>Yes / No</td>
<td>Comments / Reason discontinued</td>
</tr>
<tr>
<td>------------</td>
<td>----------------</td>
<td>----------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>Felbatol</td>
<td>(felbamate)</td>
<td>□Yes □No</td>
<td></td>
</tr>
<tr>
<td>Gabitril</td>
<td>(tiagabine)</td>
<td>□Yes □No</td>
<td></td>
</tr>
<tr>
<td>Banzel</td>
<td>(rufinamide)</td>
<td>□Yes □No</td>
<td></td>
</tr>
<tr>
<td>Keppra</td>
<td>(levetiracetam)</td>
<td>□Yes □No</td>
<td></td>
</tr>
<tr>
<td>Klonopin</td>
<td>(clonazepam)</td>
<td>□Yes □No</td>
<td></td>
</tr>
<tr>
<td>Lamictal</td>
<td>(lamotrigine)</td>
<td>□Yes □No</td>
<td></td>
</tr>
<tr>
<td>Lyrica</td>
<td>(pregabalin)</td>
<td>□Yes □No</td>
<td></td>
</tr>
<tr>
<td>Mysoline</td>
<td>(primidone)</td>
<td>□Yes □No</td>
<td></td>
</tr>
<tr>
<td>Neurontin</td>
<td>(gabapentin)</td>
<td>□Yes □No</td>
<td></td>
</tr>
<tr>
<td>Phenobarbital</td>
<td></td>
<td>□Yes □No</td>
<td></td>
</tr>
<tr>
<td>Tegretol</td>
<td>(carbamazepine)</td>
<td>□Yes □No</td>
<td></td>
</tr>
<tr>
<td>Tegretol XR</td>
<td></td>
<td>□Yes □No</td>
<td></td>
</tr>
<tr>
<td>Topamax</td>
<td>(topiramate)</td>
<td>□Yes □No</td>
<td></td>
</tr>
<tr>
<td>Trileptal</td>
<td>(oxcarbazepine)</td>
<td>□Yes □No</td>
<td></td>
</tr>
<tr>
<td>Valium</td>
<td>(diazepam)</td>
<td>□Yes □No</td>
<td></td>
</tr>
<tr>
<td>Vimpat</td>
<td>(lacosamide)</td>
<td>□Yes □No</td>
<td></td>
</tr>
<tr>
<td>Zarontin</td>
<td>(ethosuximide)</td>
<td>□Yes □No</td>
<td></td>
</tr>
<tr>
<td>Zonegran</td>
<td>(zonisamide)</td>
<td>□Yes □No</td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td>□Yes □No</td>
<td></td>
</tr>
</tbody>
</table>

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 □ Yes □ No 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:

<table>
<thead>
<tr>
<th>Surgery Type</th>
<th>Date of Surgery</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<tr>
<td>For Women:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tubal ligation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hysterectomy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oophorectomy</td>
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</tr>
</tbody>
</table>

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: 

<table>
<thead>
<tr>
<th>Health Problem</th>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Migraine Headaches</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strokes/Heart Attacks</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression or Suicide</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sudden Death Under Age 40</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hip Fracture in Parents</td>
<td></td>
<td></td>
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</tbody>
</table>

Other: 

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
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)?

<table>
<thead>
<tr>
<th>Substance</th>
<th>Usual amount and frequency</th>
<th>Check type:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tobacco</td>
<td>□ Never □ Less than 1 pack a day □ 1 or more packs a day</td>
<td></td>
</tr>
<tr>
<td>Caffeine</td>
<td>□ Never □ Less than 4 servings per day □ 4 or more servings per day</td>
<td></td>
</tr>
<tr>
<td>Marijuana</td>
<td>□ Never □ Occasionally □ Daily</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>□ Coffee □ Tea □ Pop □ Energy drinks □ Other</td>
</tr>
</tbody>
</table>

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
### FOR WOMEN:

At what age did you start menstruating?  

What is your usual cycle (in days)?  

Are your cycles regular?  

Are you sexually active?  

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?  

Are you currently pregnant?  

Are you planning to become pregnant?  

How many biological children do you have?  

Have you had any miscarriages?  

Have you had any premature deliveries?  

Have you had any birth defects?  

What is your current stage of menopause?  

Are you on hormonal replacement therapy?  

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

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For Office Use only:

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