

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 call our Intake Coordinator or one of our Patient Services Coordinators at (952) 525-2400 for assistance. If you need additional space, please attach additional page(s) and write in the number of the question you are answering.

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 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 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.)

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> No clear precipitating factors | <input type="checkbox"/> Ovulation | <input type="checkbox"/> Exercise | <input type="checkbox"/> Alcohol withdrawal |
| <input type="checkbox"/> Startle | <input type="checkbox"/> Failure to take medications | <input type="checkbox"/> Hyperventilation | <input type="checkbox"/> Using illegal drugs |
| <input type="checkbox"/> Emotional stress | <input type="checkbox"/> Taking other medications | <input type="checkbox"/> Breath holding | <input type="checkbox"/> Television |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Illness | <input type="checkbox"/> Reading | <input type="checkbox"/> Computer screens |
| <input type="checkbox"/> Lack of sleep | <input type="checkbox"/> Fever | <input type="checkbox"/> Sounds | <input type="checkbox"/> Video games |
| <input type="checkbox"/> Foods | <input type="checkbox"/> Pain | <input type="checkbox"/> Lights | <input type="checkbox"/> Don't know |
| <input type="checkbox"/> Change in eating habits | <input type="checkbox"/> Vomiting | <input type="checkbox"/> School | Other _____ |
| <input type="checkbox"/> Known low blood sugar | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Sex | _____ |
| <input type="checkbox"/> Menstruation (periods) | <input type="checkbox"/> Constipation | <input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure	_____	_____	_____ _____ _____
Video EEG Monitoring	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure	_____	_____	_____ _____ _____
CAT/CT scan	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure	_____	_____	_____ _____ _____
MRI (Magnetic Resonance Imaging)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> 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)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Carbatrol	(carbamazepine)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Depakene	(valproic acid)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Depakote	(divalproex sodium)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Depakote ER		<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Diastat	(diazepam rect)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Dilantin	(phenytoin)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

<u>Brand Name</u>	<u>Generic Name</u>	<u>Yes / No</u>	<u>Comments / Reason discontinued</u>
Felbatol	(felbamate)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Gabitril	(tiagabine)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Banzel	(rufinamide)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Keppra	(levetiracetam)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Klonopin	(clonazepam)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Lamictal	(lamotrigine)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Lyrica	(pregabalin)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Mysoline	(primidone)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Neurontin	(gabapentin)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Phenobarbital		<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Tegretol	(carbamazepine)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Tegretol XR		<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Topamax	(topiramate)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Trileptal	(oxcarbazepine)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Valium	(diazepam)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Vimpat	(lacosamide)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Zarontin	(ethosuximide)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Zonegran	(zonisamide)	<input type="checkbox"/> Yes <input type="checkbox"/> 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 & nausea abdominal pain diarrhea abnormal stool color

INTESTINE 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!