NEW VISIT INFORMATION FORM: Seizures and Related Disorders

Please complete the following information:
Date:

Name:

Telephone:

Address:

Name and address of referring physician:

Telephone # of referring physician:

Please specify what kind of doctor the referring physician is:

Personal information:
Age:

Gender:

Date of Birth:

Are you right or left-handed?:

IN A WORD, WHAT IS THE MAIN REASON FOR BEING REFERRED?

EPISODE TYPES

When did your first episode begin?

Please list for each different kind of episode type that you have, what happens during the episode.

Episode Type#l: Age of onset: _____ . Age it stopped (if applicable): _____
Average frequency per day, month or year: _____

Maximum frequency per day, month or year: _____

Anything that tends to bring it on (e.g. lack of sleep, alcohol, etc.): _____

What are you typically doing it when it comes on?

List step by step, from start to finish the things you notice when experiencing this type of seizure:

List step by step, from start to finish, what others notice when they see you having an episode:

How long does the episode typically last:

What symptoms do you have after the episode finishes:

Independent of the episodes, do you ever experience jerking movements of the arms or legs:

Episode Type#2: Age of onset:

age frequency per day, month or year:

Maximum frequency per day, month or year:

Anything that tends to bring it on (e.g. lack of sleep, alcohol, etc.):

What are you typically doing it when it comes on?

List step by step, from start to finish the things you notice when experiencing this type of episode:

Age it stopped (if applicable):

List step by step, from start to finish, what others notice when they see you having an episode:

How long does the episode typically last:

What symptoms do you have after the episode finishes:

Independent of the episodes, do you ever experience jerking movements of the arms or legs:

Episode Type#3: Age of onset: Age it stopped (if applicable):

Average frequency per day, month or year:

Maximum frequency per day, month or year:

Anything that tends to bring it on (e.g. lack of sleep, alcohol, etc.):

What are you typically doing it when it comes on?

List step by step, from start to finish the things you notice when experiencing this type of episode:

List step by step, from start to finish, what others notice when they see you having an episode:

How long does the episode typically last:

What symptoms do you have after the episode finishes:

Independent of the episodes, do you ever experience jerking movements of the arms or legs:

Did you experience dizziness and/or lack of balance? If so, complete the following:

Circle the symptoms that best describe your dizziness: (spinning, drunk, motion sickness, lightheaded, floating, feeling giddy, feeling like you left your body, fogginess, cloudiness, other):

Was there spinning? Did the world around you seem to spin? Did your head seem to spin more than the world around you?

If the room around you was spinning, what direction did it move?:

Did you feel off-balance? Did this occur even at times when the dizziness was not present?:

Related Questions

Any history of similar episodes in the past, specify:_____

If so, how often do episodes occur?:

_____

Have you been diagnosed with a vestibular disorder?_____

Did you experience palpitations?_____

Did it get worse with any particular positions of the head or body?:_____

Was it relieved with any particular positions of the head or body?:_____

Any ringing or roaring sounds in the ears, or abnormal sensation of fullness?:_____

_____

Any particular places in which the episodes occur?_____

Any associated nausea or vomiting?:_____

Any history of hearing ioss?:_____

Have you been treated with antibiotics or other new medications recently?:_____
Does the dizziness remind you of the feeling we all get upon arising from a lying position too quickly?:

_____

_____

Any associated headache, weakness or numbness in a specific part of the body?:_____

Do you have difficulty with coordination in a part of the body?:_____

During an episode, do you have loss of consciousness complete or partial?:_____

specify:_____

Anything that brought episodes on?: (ex. Acute bleeding, drinking alcohol or using drugs, head trauma, dialysis, taking a diuretic, poor eating that day, severe sweating, change in blood pressure medication, sudden pain or fear or unpleasant sight, wearing tight-fitting collar, a specific activity, straining, urinating or having a bowel movement, hyperventilating, change in a diabetic medication, etc.) _____
Specify:_____

_____

_____

Past Medical History:

Were there any difficulties when your mother was pregnant with you?_____

_____

Was your birth full-term?_____

Were you delivered with the use of forceps or cesarean section?_____

_____

If so, do you know why?_____

Early Developmental History:

As far as you know, were you walking and talking at the normal times?_____

Medical Problems:

Do you have a history of any of the following. If so, specify: (Any abnormalities in brain formation, tuberous sclerosis, mental retardation, pimple rash on the face, Sturge-Weber disease, large red blotches on the face or scalp, neurofibromatosis, head trauma, episodes of lack of oxygen, known scarring in the brain, history of seizures at the time of fevers during infancy, episodes occurring during use of any specific medications such as psychological drugs, alcohol abuse, drug abuse, episodes when alcohol or drugs were rapidly stopped, infections such as encephalitis, meningitis, sinusitis, abscess/focal area of infection in the brain, HIV+ or AIDS, toxoplasmosis, tuberculosis, syphilis, lyme disease, tick bites, skin rashes, dementia such as Alzheimer's disease, high blood pressure, eclampsia, collagen vascular disorders such as lupus, butterfly rash on the face, joint swellings, ulcerations in the mouth or genital area, Sjogren's disease, dry eyes, dry mouth, any structural lesions in the brain, tumors, multiple sclerosis, vascular abnormalities in the brain, strokes, heart disease such as enlargement of chambers of the hear, irregular heart rhythms, heart valve abnormalities, blood clots, abnormally prolonged Q-T interval on EKG, metabolic abnormalities such as low sodium, low blood sugars, calcium abnormalities, parathyroid disease, deterioration in thinking functioning or change in behavior, peripheral neuropathy with numbness in the ends of the limbs).

_____

_____

_____

_____

Please list any medical problems that you have had, including dates that these began and what the current status of these problems are. Please include any psychiatric history. Include prior surgeries as well:

_____

_____

_____

Tobacco:

Do you currently use tobacco? If so, do you smoke or chew tobacco?

How much do you smoke per day? How long have you been a smoker?

If you do not use tobacco now, but you were a former user, how long ago did you quit?

How long did you use tobacco before you quit?

Alcohol:

Do you currently drink alcohol?

How much do you drink in a given day or week?

Have you ever had a drinking problem? When was your last drink?

Do you have blackouts, seizures, injuries, or other problems due to drinking?

Have you had problems with work or relationships due to drinking?

Drug Use:

Do you use illegal drugs?

If so, what types of drugs, how much, and how often?

How long have you been using illegal drugs?

If you do not use illegal drugs currently but did in the past, how long ago did you quit?

How long were you using illegal drugs before you quit?

Allergies:

Do you have any history of side effects from medications or dyes used for testing?

If so, please specify.

FAMILY HISTORY

Is there any history of neurological disorders in the family? If so, please specify:

Family history of seizures?:

PRIOR DIAGNOSTIC WORK UP

EEG:

Please specify the dates and places where an EEG may have been performed in the past and what the results were.

Date of EEG#I:

Place of EEG:

Type of EEG (routine, 24 hour ambulatory, video-EEG):

Results of EEG:

Date of EEG#2:

Place of EEG:

Type of EEG (routine, 24 hour ambulatory, video-EEG):

Results of EEG:

Date of EEG#3:

Place of EEG:

Type of EEG (routine, 24 hour ambulatory, video-BEG):

Results of EEG:

Head CT Scan:

Date of CT#I:

Place of CT:

Type of CT: (with or without contrast/dye):

Results of CT

Date of CT#2:

Place of CT:

Type of CT: (with or without contrast/dye):

Results of CT.

MRI of the head:

Date ofMRl#1:

Place of MRI:

Type of MRI: (with or without contrast/dye):

Results of MRI.

Date of MRI#2:

Place of MRI:

Type of MRI: (with or without contrast/dye):

Results of MRI:

Date of MRW3:

Place of MRI:

Type of MRI: (with or without contrast/dye):

Results of MRI:

Neuropsychological Testing

Please specify the dates, places, and results of any memory or thinking testing that you may have had.

Other Tests:

TREATMENTS

Current Medications: Please specify your current antiepileptic drugs and other medications. Specify the amount of milligrams per pill and how you take the pills per day. Please specify whether you were ever on higher doses, and if so, why the dose was reduced.

Name of the medication or other kind of treatment

When did you start?

When did you stop?. Why was it stopped?

What side effects did it cause?

Was it effective?:

Name of the medication or other kind of treatment

When did you start?

When did you stop?. Why was it stopped?

What side effects did it cause?

Was it effective?:

Name of the medication or other kind of treatment

When did you start?

When did you stop?. Why was it stopped?

What side effects did it cause?

Was it effective?:_____

Name of the medication or other kind of treatment_____

When did you start?

_____

When did you stop?_____· Why was it stopped?_____

What side effects did it cause?_____

Was it effective?:_____

Name of the medication or other kind of treatment

_____

When did you start?_____

When did you stop?_____· Why was it stopped?_____

What side effects did it cause?_____

Was it effective?:_____

Name of the medication or other kind of treatment

_____

When did you start?

_____

When did you stop? Why was it stopped?

What side effects did it cause?

_____

Was it effective?:

_____

Name of the medication or other kind of treatment_____

When did you start?_____

When did you stop?_____· Why was it stopped?_____

What side effects did it cause?_____

Was it effective?:

_____

Name of the medication or other kind of treatment_____

When did you start?

When did you stop?_____· Why was it stopped?_____

What side effects did it cause?_____

Was it effective?:_____

PSYCHOSOCIAL

Please describe any problems you may feel you are having in memory or thinking:

Please specify your highest level of education:

Please specify your current and past occupation:

Please describe your working and past relationships (married, divorced, living with, living in a supervised residence, etc.)

Is there any family history of psychiatric illnesses such as depression, bipolar disorder, major anxiety disorder?

Please describe any difficulties you are aware of in your mood or quality of life. How much enjoyment do you get from your daily life? Do you feel depressed? Do others find you to be irritable?