Health Questionnaire

Name: _____ Date: _____ DOB: _____

Chief Complaint: _____

Brief History of Problem: _____

_____

_____

Describe any warning symptoms prior to your spells. _____

_____

How often are the episodes occurring? _____

Have you been treated with any seizure medications in the past. Please describe response, side effects, and maximum dosage used (if known) _____

Dilantin/phenytoin
Tegretol/carbamazepine
Phenobarbital
Mysoline/primidone
Depakote/valproic acid
Neurontin/gabapentin
Keppra/levetiracetam
Lamictal/lamotrigine
Trileptal/oxcarbamazepine
Vimpat/lacosamide
Topamax/topiramate
Lyrica/ pregabalin
Other

Women Only: Any plans for pregnancy?_____

Past Medical History: (Please check if applicable)

___ High Blood Pressure ___ Diabetes ___ Stroke ___ Heart Problems ___ Lung Problems
___ Glaucoma ___ Cancer ___ Anemia ___ Liver disease ___ Blood Clots
___ Epilepsy ___ Gastrointestinal ___ Gynecological Problems
Other: _____
_____

Surgical History: _____

_____

Habits:

Alcohol _____ # drinks/week Cigarettes _____ # cig/day x _____ # years _____ year quit
Other tobacco usage: _____ Current frequency: _____
Caffeine _____ # cups/day Recreational Drugs: _____

Family History:

_____ Migraine
_____ Epilepsy
_____Cerebral Aneurysm
_____Multiple Sclerosis
_____Parkinsons
_____Alzheimer/Dementia
_____High Blood Pressure
_____ Diabetes
_____ Stroke
_____ Heart Problems
_____ Lung Problems
_____ Glaucoma
_____ Cancer
_____ Anemia
_____ Liver Disease
_____ Blood Clots
_____ Osteoporosis

Other: _____

Allergies: _____

_____

Name: _____ Date: _____ DOB: _____

Current Medications:

Medication	Dosage	Action

Review of Current/Recent Symptoms: (check all that are applicable)

General: ___ Fever ___ Chills ___ Weight Loss ___ Weakness

Skin: ___ Rash ___ Itching

Hematopoietic: ___ Bruising ___ Bleeding ___ Anemia

HEENT: ___ Vision changes ___ Double vision ___ Glaucoma ___ Hearing problems
___ Vertigo

Respiratory: ___ Cough ___ Coughing Blood ___ Shortness of Breath ___ Infections

Cardiovascular: ___ Chest Pain ___ Murmurs ___ Pain in legs with walking ___ Swelling in the legs

Gastro-Intestinal: ___ Constipation ___ Diarrhea ___ Bleeding ___ Hemorrhoids ___ Indigestion
___ Hepatitis

Genito-Urinary: ___ Burning ___ Bleeding leaking (incontinence) ___ Flank pain ___ Loss of erections

Muscle-skeletal: ___ Joint Pain ___ Weakness ___ Back pain ___ Cramps

Neurologic: ___ Headache ___ Dizziness ___ Seizures ___ Blackouts ___ Depression
___ Sleeping problems
Other:_____
_____

Other Comments:_____
_____

_____ _____
Signature Date