

**Minnesota Epilepsy Group, P.A.**  
**Adult Patient Data**

Date: \_\_\_\_\_

Patient Name \_\_\_\_\_ Sex: M / F

Nickname \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ County \_\_\_\_\_ ZIP \_\_\_\_\_

Phone Number Home: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_

Other: (\_\_\_\_) \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Send correspondence to the following name/address(s):**

Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Name of person filling out this form \_\_\_\_\_ Relationship \_\_\_\_\_

**Legal Custody:**

\_\_\_\_ Self      \_\_\_\_ Mother      \_\_\_\_ Other relative      \_\_\_\_ Ward of state  
\_\_\_\_ Joint      \_\_\_\_ Father      \_\_\_\_ Guardian, non-relative      \_\_\_\_ Other \_\_\_\_\_

**Name and Address of Next of Kin:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ County \_\_\_\_\_ ZIP \_\_\_\_\_

Phone Number Home: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_

**In Case of Emergency, Please Contact:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone Number Home: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_

**Residential Facility Information:**

Name of Facility \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ County \_\_\_\_\_ ZIP \_\_\_\_\_

Name of Contact Person: \_\_\_\_\_

Phone: \_\_\_\_\_

Finance Worker \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Medicare # \_\_\_\_\_ Part B: No Yes Expiration Date \_\_\_\_\_

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Medical Assistance # \_\_\_\_\_

State \_\_\_\_\_ County \_\_\_\_\_

Social Worker \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

**Primary Insurance Company Name** \_\_\_\_\_

Send claims to: Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Contact Person \_\_\_\_\_ Group # \_\_\_\_\_ Policy Holder \_\_\_\_\_

Policy holder's Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Company employing policy holder: \_\_\_\_\_ Policy is Group - Individual

**Secondary Insurance Company Name** \_\_\_\_\_

Send claims to: Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Contact Person \_\_\_\_\_ Group # \_\_\_\_\_ Policy Holder \_\_\_\_\_

Policy holder's Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Company employing policy holder: \_\_\_\_\_ Policy is Group - Individual

**Medications currently taken for seizures:**

Drug	Pill Size(s)	Doses in 24 hours	Time (with dose medication) taken
<i>Example: Dilantin</i>	<i>100 mg 30 mg</i>	<i>330 mg</i>	<i>8 a.m. 130 mg    8 p.m. 200 mg</i>

**Other Medication:**

Drug	Dose	Taken For

**List all seizure medications prescribed in the past:**

Drug	Why Stopped

**Allergies:** \_\_\_\_\_

**Seizure History**

Age at first seizure \_\_\_\_\_ Date of first seizure \_\_\_\_\_

Describe the events of the first seizure/spell. What were the circumstances surrounding the first seizure?  
What was the seizure like?

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To your knowledge, what are the names of your seizure types?

1. \_\_\_\_\_ 3. \_\_\_\_\_  
2. \_\_\_\_\_ 4. \_\_\_\_\_

What is the longest period of time that you have been seizure-free?

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**Please describe each of your seizure types and how often you have each type.**

**Type #1:** \_\_\_\_\_

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**Type #2:** \_\_\_\_\_

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**Type #3:** \_\_\_\_\_

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**Type #4:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you employed? Yes \_\_\_\_ No \_\_\_\_ If not, when did you work last? \_\_\_\_\_

Have you ever lost a job because of your seizures? Yes \_\_\_\_ No \_\_\_\_ Please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have seizures interfered with your life? If so, how? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What do you hope will be accomplished during your evaluation at Minnesota Epilepsy Group? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_