

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?

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?

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

Type #1: _____

Type #2: _____

Type #3: _____

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? _____

