

Minnesota Epilepsy Group, P.A.
Adult Patient History

Date: _____

Patient Name _____ Sex: M / F

Nickname _____ Age _____ Date of Birth ____/____/____

Street Address _____

City _____ State _____ County _____ ZIP _____

Phone Number Home: (____) _____ Work: (____) _____

Other: (____) _____ SS#: _____ - _____ - _____

Guardianship Information:

Name _____ Relationship _____

Street Address _____

City _____ State _____ County _____ ZIP _____

Phone Number Home: (____) _____ Work: (____) _____

Past Medical Information

From whom should we request your medical records? Please include clinic name, first and last names of doctors, complete addresses and telephone numbers. List additional sources of treatment on back.

Physician treating you for seizures: _____ Specialty: _____

Name of Clinic: _____

Address _____

City _____ State _____ ZIP _____

Phone: (____) _____ Dates of care _____

Physician: _____ Specialty: _____

Name of Clinic: _____

Address _____

City _____ State _____ ZIP _____

Phone: (____) _____ Dates of care _____

Physician: _____ Specialty: _____

Name of Clinic: _____

Address _____

City _____ State _____ ZIP _____

Phone: (____) _____ Dates of care _____

OVER →

List all Psychiatrist/Psychologist/Counseling Services. Please list any other Counseling Services on back.

Psychiatrist/Psychologist/Counseling Services _____
Specialty: _____
Address _____
City _____ State _____ ZIP _____
Phone: (____) _____ Dates of care _____

List all recent hospitalizations. Please list any hospitalizations on back.

Name of Hospital _____
Address _____
City _____ State _____ ZIP _____
Dates of hospitalization _____ Reason for hospitalization _____
Phone: (____) _____

Name of Hospital _____
Address _____
City _____ State _____ ZIP _____
Dates of hospitalization _____ Reason for hospitalization _____
Phone: (____) _____

Name of Hospital _____
Address _____
City _____ State _____ ZIP _____
Dates of hospitalization _____ Reason for hospitalization _____
Phone: (____) _____

CAT (CT) Scan – History

Have you ever had a CAT or CT scan of the head? Yes _____ No _____

If yes, please complete for most recent CT scan:

Name of Facility _____
Address _____
City _____ State _____ ZIP _____
Phone (____) _____ Date of test: _____
Results, if known _____

MRI (Magnetic Resonance Imaging) History

Have you ever had an MRI scan of the head? Yes _____ No _____

If yes, where:

Name of Facility _____
Address _____
City _____ State _____ ZIP _____
Phone (____) _____ Date of test: _____
Results, if known _____