

Minnesota Epilepsy Group, P.A.[®]
Pediatric Patient Data

Date: _____

Patient Name _____ Sex: M / F

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

Street Address: _____

City _____ State _____ County _____ ZIP _____

Phone Number (____) _____ SS#: _____ - _____ - _____

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 Number: _____

Send correspondence to the following name and address:

Name _____

Address _____

City _____ State _____ ZIP _____

Name _____

Address _____

City _____ State _____ ZIP _____

Will your religious beliefs affect any treatment that will be rendered: ___ Yes ___ No

Comments: _____

Medications currently taken for seizures:

Drug	Size of tablet in mg/tablet or mg/ml-liquid	When medication taken (times)	Total daily dose (mg)

In your judgment, is your child presently experiencing medication side effects? If so, what are they?

Do you know what your child's most recent antiepileptic drug levels were?

Drug	Level	Date of Level

List all seizure medications prescribed in the past:

Past Drug	Highest Daily Dose	Why Discontinued

Does your child take his/her medications independently? _____

How often does your child miss his/her medications? _____

Are any of your child's medications taken at school? _____

If your child takes medications other than the ones for seizures, please list:

Drug	Dose	Taken For

Seizure History

Age of onset of seizures _____ Date of onset of seizures _____

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 child's seizure types?

1. _____ 3. _____

2. _____ 4. _____

Did your child have seizures related to fever as a baby? _____

What brings on your child's seizures? (Check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> No clear precipitating factors | <input type="checkbox"/> Hyperventilation (fast breathing) |
| <input type="checkbox"/> Startle | <input type="checkbox"/> Breath holding |
| <input type="checkbox"/> Emotional Stress | <input type="checkbox"/> Reading |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Sounds |
| <input type="checkbox"/> Lack of sleep | <input type="checkbox"/> Lights |
| <input type="checkbox"/> Foods | <input type="checkbox"/> School |
| <input type="checkbox"/> Change in eating habits | <input type="checkbox"/> Sex |
| <input type="checkbox"/> Known low blood sugar | <input type="checkbox"/> Alcohol |
| <input type="checkbox"/> Menstruation (periods) | <input type="checkbox"/> Alcohol withdrawal |
| <input type="checkbox"/> Ovulation | <input type="checkbox"/> Television/video games |
| <input type="checkbox"/> Failure to take medications | <input type="checkbox"/> Don't know |
| <input type="checkbox"/> Taking other medications | |
| <input type="checkbox"/> Illness | |
| <input type="checkbox"/> Fever | |
| <input type="checkbox"/> Pain | |
| <input type="checkbox"/> Constipation | |
| <input type="checkbox"/> Exercise | |

Other General Information

Have the seizures changed how your child acts in any way (please mark all that apply)?

No
 Plays less with friends
 Does not do things that he/she used to
 Grades have gone down
 Other _____

Do any of the following describe your child? If so, please mark those that apply.

<input type="checkbox"/> Not alert, sleepy	<input type="checkbox"/> Drooling	<input type="checkbox"/> Frequent infections
<input type="checkbox"/> Pale and listless	<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Headaches
<input type="checkbox"/> Bad behavior	<input type="checkbox"/> Puffiness in eyes/fingers	<input type="checkbox"/> Loss of appetite
<input type="checkbox"/> Rash	<input type="checkbox"/> Gum Swelling	<input type="checkbox"/> Upset stomach
<input type="checkbox"/> Poor coordination	<input type="checkbox"/> Unsteady on feet	<input type="checkbox"/> Slurred speech
<input type="checkbox"/> Bleeding/Bruising easily	<input type="checkbox"/> Yellowish colored skin/eyes	<input type="checkbox"/> Constipation
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Hyperactive	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Jitters	<input type="checkbox"/> Weight gain	

How did you learn of this program?

<input type="checkbox"/> Physician	<input type="checkbox"/> Psychologist
<input type="checkbox"/> Nurse	<input type="checkbox"/> Social Worker
<input type="checkbox"/> Voluntary organization	<input type="checkbox"/> Another patient
<input type="checkbox"/> Newsletter, magazine, etc.	<input type="checkbox"/> Other _____
<input type="checkbox"/> Counselor	

Name _____

& Address of _____

Above _____

Street Address _____

City	State	County	Zip
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In the space provided in the next 2 pages, please describe as completely as possible what your child's seizures are like. You may need to gather additional information from others who have observed your child's seizures. If your child has several types of seizures, please use a separate page for a description of each seizure type.

Describe each seizure type from beginning to end. We have found that the best seizure descriptions are those which use everyday language and no medical terminology. Include the following information in your descriptions:

- Does your child have a warning when one is going to happen? If yes, what is it like?
- How does the seizure begin?
- Is the onset sudden (a few seconds) or gradual (up to a minute or more)?
- How long does the seizure last?
- What does your child do during the seizure?
- Does he/she remember events that occur during the seizure?
- Does he/she lose consciousness, partially or completely, during the seizure?
- How does your child behave after a seizure (does he/she become irritable, confused, sleepy, resume activity, other)?

Type #1: _____ _____ _____ _____			
Summary:		Seizure frequency:	
Warning or aura: No Yes Sometimes	Loss of consciousness: No Yes Sometimes	How many: _____ Frequency: _____ _____ hour _____ day _____ week _____ month _____ year	If frequency is fewer than one per year, what is the total number of this type of seizure? _____ _____
Time of seizure occurrence:			
____ Morning	____ During sleep	When was the last time a seizure of this type occurred? _____ _____	
____ Afternoon	____ Before or during period		
____ Evening	____ Other _____		
____ No particular time of day			

Type #2: _____ _____ _____ _____			
Summary:		Seizure frequency:	
Warning or aura: No Yes Sometimes	Loss of consciousness: No Yes Sometimes	How many: _____ Frequency: _____ _____ hour _____ day _____ week _____ month _____ year	If frequency is fewer than one per year, what is the total number of this type of seizure? _____ _____
Time of seizure occurrence:			
____ Morning	____ During sleep	When was the last time a seizure of this type occurred? _____ _____	
____ Afternoon	____ Before or during period		
____ Evening	____ Other _____		
____ No particular time of day			

Type #3: _____

Summary:		Seizure frequency:	
Warning or aura: No	Yes Sometimes	How many: _____	If frequency is fewer than one per year, what is the total number of this type of seizure? _____ _____
Loss of consciousness: No	Yes Sometimes	Frequency: _____	
Confusion afterwards: No	Yes Sometimes	____ hour ____ day	
		____ week ____ month	
		____ year	

Time of seizure occurrence:	
<input type="checkbox"/> Morning <input type="checkbox"/> During sleep <input type="checkbox"/> Afternoon <input type="checkbox"/> Before or during period <input type="checkbox"/> Evening <input type="checkbox"/> Other _____ <input type="checkbox"/> No particular time of day	When was the last time a seizure of this type occurred? _____ _____

Type #4: _____

Summary:		Seizure frequency:	
Warning or aura: No	Yes Sometimes	How many: _____	If frequency is fewer than one per year, what is the total number of this type of seizure? _____ _____
Loss of consciousness: No	Yes Sometimes	Frequency: _____	
Confusion afterwards: No	Yes Sometimes	____ hour ____ day	
		____ week ____ month	
		____ year	

Time of seizure occurrence:	
<input type="checkbox"/> Morning <input type="checkbox"/> During sleep <input type="checkbox"/> Afternoon <input type="checkbox"/> Before or during period <input type="checkbox"/> Evening <input type="checkbox"/> Other _____ <input type="checkbox"/> No particular time of day	When was the last time a seizure of this type occurred? _____ _____

Health History: Child

A. Pregnancy and birth history:

Duration of pregnancy (answer full term if delivery was within two weeks of expected time).

_____ Full term
_____ Premature How early? _____ weeks
_____ Overdue How late? _____ weeks

Were there any complications with pregnancy? _____ Yes _____ No

If yes, please mark all that apply:

_____ Urinary infections	_____ High blood pressure
_____ Accidents	_____ Toxemia
_____ Seizures	_____ Measles/Rubella
_____ Substance abuse (alcohol, drugs)	_____ Diabetes
_____ X-rays	_____ Any illness with a fever
_____ Vaginal infections of any kind	_____ Other _____
_____ Bleeding or spotting	

B. Labor and delivery

Length of labor: _____ hours

Was the delivery: _____ Natural
_____ Induced
_____ C-Section

Were there any problems during delivery? _____ Yes _____ No

Forceps used _____ Yes _____ No

Born breech _____ Yes _____ No

Did the baby breathe immediately? _____ Yes _____ No

Child's birth weight: _____

APGAR Scores if known: _____ at 1 minute
_____ at 5 minutes
_____ Other

C. Newborn history:

Did your child have any problems following birth? _____ Yes _____ No

If yes, please mark all that apply: _____ Jaundice (Yellow)
_____ Cyanosis (Blue)
_____ Seizures
_____ Other _____

Length of newborn hospital stay? _____

Did the baby have problems feeding? _____ Yes _____ No

If yes, explain: _____

Additional Comments: _____

D. Developmental Milestones

For the following items, please mark those things your child can do, and the age at which she/he learned it. Respond in months, or years and months. If you cannot remember the exact age, list the approximate age.

Example: Age: 2 months OR 3 years 4 months

1. Fine Motor and Self-Care Skills

- Grasps objects within reach Age: _____
- Transfers objects from hand to hand Age: _____
- Picks up small objects (Cheerios) Age: _____
- Uses spoon or fork to feed self Age: _____
- Buttons large buttons Age: _____
- Can dress self, except tying shoes Age: _____
- Uses pencil or crayon to scribble Age: _____
- Uses pencil or crayon to draw recognizable pictures Age: _____
- Prints letters Age: _____
- Can print or write name Age: _____
- Is toilet regulated Age: _____
(stays dry if placed on the toilet on a regular schedule) Age: _____
- Is toilet trained Age: _____
- Can care for self with minimal supervision Age: _____
- Ties shoes Age: _____

2. Motor Development and Coordination

- Picks head up Age: _____
- Rolls over Age: _____
- Crawls Age: _____
- Sits with support Age: _____
- Sits without support Age: _____
- Stands, holding onto something Age: _____
- Stands alone Age: _____
- Walks, holding on Age: _____
- Walks alone Age: _____
- Climbs Age: _____
- Runs Age: _____
- Rides a trike Age: _____
- Rides a bike Age: _____

3. Language Skills

- Coos or gurgles Age _____
- Babbles (repeats same sound over and over) Age: _____
- Imitates sounds (babbling that sounds like real speech) Age: _____
- Says single word Age: _____
- Says two to three words Age: _____
- Says sentences Age: _____
- Says rhymes, poems Age: _____
- Understands and responds to yes and no command Age: _____
- Understands and can comply with simple commands ("sit down") Age: _____
- Follows directions of 2-3 parts (go to your room, pick up your toys and hang up your clothes) Age: _____
- Counts Age: _____
- Reads Age: _____
- Writes cursive Age: _____
- Does simple math Age: _____
- Tells time Age: _____

Do you think your child's speech and language is normal? Yes No
 If no, explain _____

4. Alternate Communication

(If your child does not speak, please complete this section.)

- Points to indicate wants Age: _____
- Uses gestures Age: _____
- Uses sign language Age: _____
- Uses a communication board Age: _____

5. Behavior (Please mark any term that you think describes your child at least half the time)

- | | | |
|---|---|--|
| <input type="checkbox"/> Active child | <input type="checkbox"/> Cooperative | <input type="checkbox"/> Friendly |
| <input type="checkbox"/> Easygoing | <input type="checkbox"/> Moody | <input type="checkbox"/> Talkative |
| <input type="checkbox"/> Shy | <input type="checkbox"/> Aggressive | <input type="checkbox"/> Selfish |
| <input type="checkbox"/> Cries easily | <input type="checkbox"/> Helpful | <input type="checkbox"/> Attentive |
| <input type="checkbox"/> Short attention span | <input type="checkbox"/> Wide mood swings | <input type="checkbox"/> Hyperactive |
| <input type="checkbox"/> Has a strong temper | <input type="checkbox"/> Withdrawn | <input type="checkbox"/> Overdependent |
| <input type="checkbox"/> Irritable | <input type="checkbox"/> Depressed | <input type="checkbox"/> Impulsive |
| <input type="checkbox"/> No confidence | <input type="checkbox"/> Poor self-esteem | |

What concerns do you have about your child's behavior? _____

What does your child enjoy doing (favorite toys, activities)? _____

How long will he/she stay with an activity he/she enjoys (approximate number of minutes)?

6. Other

Does your child have emotional problems? _____ Yes _____ No
Please describe: _____

Has he/she had counseling for emotional problems? _____ Yes _____ No

Does your child sleep well? _____ Yes _____ No

Do you think your child is usually happy? _____ Yes _____ No

Does your child get along well with other children? _____ Yes _____ No

Do you have problems with discipline? _____ Yes _____ No

Does your child seem to have frequent accidents or injuries? _____ Yes _____ No

Does your child smoke? _____ Yes _____ No

Does your child drink alcohol? _____ Yes _____ No

Does your child have problems seeing? _____ Yes _____ No

_____ Wears glasses _____ Contact lens

Does your child have problems hearing? _____ Yes _____ No

_____ Hearing aid

Is your child on a special diet? _____ Yes _____ No

If yes, describe _____

Is your child well coordinated? _____ Yes _____ No

Does your child have good muscle strength? _____ Yes _____ No

Does your child have any problems with sense of touch? _____ Yes _____ No

Does your child use special devices to walk? _____ Yes _____ No

If yes, please mark:

_____ Crutches _____ Wheelchair

_____ Cane _____ Prosthesis

_____ Walker

Is your child: _____ right-handed _____ left-handed _____ undetermined

How does your child do with fine finger skills (drawings, cutting, coloring)?

_____ Poor _____ Fair _____ Good

E. Childhood Diseases/Illnesses

1. Mark any illness your child has had since infancy.

_____ Ear infections _____ Hay fever _____ Frequent colds _____ Bowel or bladder problems

_____ Headaches _____ Encephalitis _____ Hives _____ Other _____

_____ Rashes _____ Meningitis

2. Is your child allergic to any medications? Yes No

Drug name Reaction (rash, difficulty breathing, etc.)

Has your child ever had an allergic reaction to X-ray dyes? _____

Does your child have any food or other allergies (please list)? _____

3. Describe in detail any injury that caused loss of consciousness, confusion or a dazed state.

a. _____
b. _____
c. _____

4. Does your child have any other chronic conditions or illnesses other than epilepsy?

Yes No If yes, please describe:

5. Immunizations

Please marks the shots Was this series completed?
your child has had:

_____ DPT _____ Yes _____ No
_____ MMR _____ Yes _____ No
_____ Polio _____ Yes _____ No
_____ TB Test _____ Yes _____ No
_____ HIB _____ Yes _____ No

Any reaction to immunizations? Please explain: _____

F. Family History

Name of child's father: _____ Age: _____

Name of child's mother: _____ Age: _____

Name of brother(s):	Birth date	Names of sister(s):	Birth date

(Continue on back if more than four of each)

Have any immediate family members (child's mother, father, brother(s), sister(s) ever had seizures or other neurological problems? Yes No If yes, describe:

Name	Description

Have any immediate family members (child's mother, father, brother(s), sister(s) ever been developmentally delayed? Yes No If yes, describe:

Have any other family members (grandparents, aunts, uncles, cousins) even had seizures or other neurological problems? Yes No If yes, describe:

Name	Relation	Problem

School

What grade is your child in now? (circle the appropriate grade)
 Daycare Preschool KG 1 2 3 4 5 6 7 8 9 10 11 12

Is your child enrolled in special classes? Yes No

If yes, please state name of program: _____

Do you consider his/her schoolwork to be satisfactory? Yes No

Does your child enjoy school? Yes No

Has your child missed more than five days of school in the past year? Yes No

Was this because of his/her seizures? Yes No

Has your child repeated a grade in school? Yes No

If yes, which one? _____

Have you ever been told that your child has a learning disability? Yes No

Do you think your child has problems with any of the following:

- Reading Getting assignments done
- Sitting still Obeying the teacher
- Arithmetic Writing/printing
- Speech or language Paying attention
- Memory Other _____
- Spelling

