

**Minnesota Epilepsy Group, P.A.<sup>®</sup>**  
**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?

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**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?

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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	

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**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 \_\_\_\_\_

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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)?

<b>Type #1:</b> _____ _____ _____ _____			
<b>Summary:</b>		<b>Seizure frequency:</b>	
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? _____ _____
<b>Time of seizure occurrence:</b>			
____ 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			

<b>Type #2:</b> _____ _____ _____ _____			
<b>Summary:</b>		<b>Seizure frequency:</b>	
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? _____ _____
<b>Time of seizure occurrence:</b>			
____ 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

