

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 Other _____
 Plays less with friends
 Does not do things that _____
he/she used to
 Grades have gone down _____

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

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

Type #2: _____

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

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

_____ Accidents

_____ Seizures

_____ Substance abuse (alcohol, drugs)

_____ X-rays

_____ Vaginal infections of any kind

_____ Bleeding or spotting

_____ High blood pressure

_____ Toxemia

_____ Measles/Rubella

_____ Diabetes

_____ Any illness with a fever

_____ Other _____

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)
- _____ 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)

- | | | |
|----------------------------|------------------------|---------------------|
| _____ Active child | _____ Cooperative | _____ Friendly |
| _____ Easygoing | _____ Moody | _____ Talkative |
| _____ Shy | _____ Aggressive | _____ Selfish |
| _____ Cries easily | _____ Helpful | _____ Attentive |
| _____ Short attention span | _____ Wide mood swings | _____ Hyperactive |
| _____ Has a strong temper | _____ Withdrawn | _____ Overdependent |
| _____ Irritable | _____ Depressed | _____ Impulsive |
| _____ No confidence | _____ 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 mark the shots
your child has had:

Was this series completed?

_____ 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

