

**Minnesota Epilepsy Group, P.A.<sup>®</sup>**  
**Pediatric Patient History**

Date: \_\_\_\_\_

Patient Name \_\_\_\_\_ Sex: M / F

Nickname \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Street Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ County \_\_\_\_\_ ZIP \_\_\_\_\_

Phone Number (\_\_\_\_) \_\_\_\_\_ SS#: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_

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**Parent or Guardian Information:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Street Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Phone Number Home: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_

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**Past Medical Data**

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 child for seizures: \_\_\_\_\_ Specialty: \_\_\_\_\_

Name of Clinic: \_\_\_\_\_

Street Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_ Dates of care: \_\_\_\_\_

Physician: \_\_\_\_\_ Specialty: \_\_\_\_\_

Name of Clinic: \_\_\_\_\_

Street Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_ Dates of care: \_\_\_\_\_

Physician: \_\_\_\_\_ Specialty: \_\_\_\_\_

Name of Clinic: \_\_\_\_\_

Street Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_ Dates of care: \_\_\_\_\_

Physician: \_\_\_\_\_ Specialty: \_\_\_\_\_

Name of Clinic: \_\_\_\_\_

Street Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_ Dates of care: \_\_\_\_\_

**Who would you like your clinic note sent to?** \_\_\_\_\_

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**List all hospitalizations from birth to present.** Continue on next page.

Name of Hospital Where Child was born \_\_\_\_\_

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: \_\_\_\_\_

Name of Hospital \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Dates of hospitalization \_\_\_\_\_ Reason for hospitalization \_\_\_\_\_  
Phone: \_\_\_\_\_

**Hospitalizations in the last 12 months:**

number of seizure-related: \_\_\_\_\_  
number of other medical: \_\_\_\_\_  
number of psychiatric-related: \_\_\_\_\_  
number of other: \_\_\_\_\_  
number of seizure-related emergency room visits in the last 12 months: \_\_\_\_\_  
number of other emergency room visits in the last 12 months: \_\_\_\_\_

**Past Diagnostic Tests Performed**

When was his/her last EEG? \_\_\_\_\_  
Has your child ever had:  
a seizure during an EEG recording? \_\_\_\_\_ Yes \_\_\_\_\_ No  
a combined video/EEG recording? \_\_\_\_\_ Yes \_\_\_\_\_ No  
skull X-rays: \_\_\_\_\_ Yes \_\_\_\_\_ No Where performed: \_\_\_\_\_  
spinal tap: \_\_\_\_\_ Yes \_\_\_\_\_ No Where performed: \_\_\_\_\_  
chromosomes: \_\_\_\_\_ Yes \_\_\_\_\_ No Where performed: \_\_\_\_\_  
blood or urine tests: \_\_\_\_\_ Yes \_\_\_\_\_ No Where performed: \_\_\_\_\_  
looking for cause of seizures: \_\_\_\_\_ Yes \_\_\_\_\_ No Where performed: \_\_\_\_\_

**CAT (CT) Scan-History**

Has your child 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 \_\_\_\_\_  
Telephone (\_\_\_\_) \_\_\_\_\_ Date Completed \_\_\_\_\_  
Results, if known \_\_\_\_\_

**MRI (Magnetic Resonance Imaging) History**

Has your child ever had an MRI scan of the head? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, please complete for most recent MRI scan:  
Name of Facility \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Telephone (\_\_\_\_) \_\_\_\_\_ Date Completed \_\_\_\_\_  
Results, if known \_\_\_\_\_