Intake Form: Epilepsy

Chief Complaint

In your own words, what brings you in today?

_____

_____

History of Present Illness (HPI)

Briefly describe your present symptoms:

_____

_____

Date symptoms began? _____

Describe the frequency of the problem *(continuous, intermittent, daily, hourly etc.)*:

_____

On a scale from 0 to 10, 0 being no problem at all and 10 being severe as possible, how would you rate it? _____

What body parts are most affected? _____

Have you previously received a diagnosis for this problem? *(circle one)* **Yes** **No**

If so, what was the diagnosis:_____

Who made the diagnosis:_____

What tests have been performed to evaluate this problem *(i.e. MRI, lab tests, etc.)*?

_____

_____

What treatments have been tried for this problem *(i.e. medications, physical therapy, etc.)*?

_____

_____

What improves the problem *(medication, rest, sitting, etc.)*?

_____

_____

What worsens the problem *(exercise, poor sleep, stress, etc.)*?

_____

_____

Has your problem interfered with your activities of daily living, such as bathing, feeding, or clothing yourself, or has it impacted your occupation? If so, what?

_____

_____

Who in your family has a similar problem?

_____

Are you interested in participating in research trials? *(circle one)* **Yes** **No** **Maybe**

Surgical History ☐ No prior surgeries or procedures

Procedure	Date (MM/YYYY)	Complications?

Review of Systems

Constitutional ☐ None of the below

☐ Fever / Chills
☐ Unintentional weight gain / loss
☐ Exercise intolerance
☐ Fatigue
☐ Night sweats
☐ Inability to sleep
☐ Sleeping too much

HEENT ☐ None of the below

☐ Blurred vision / vision loss
☐ Hearing change
☐ Nosebleeds
☐ Difficulty chewing / swallowing
☐ Change in smell / taste
☐ Double vision
☐ Ringing in the ears
☐ Hoarseness / prolonged sore throat
☐ Speech changes / difficulty
☐ Snoring

Respiratory ☐ None of the below

☐ Shortness of breath
☐ Wheezing
☐ Chronic cough

Cardiovascular ☐ None of the below

☐ Chest pain / pressure / heaviness
☐ Swelling of feet / ankles
☐ Palpitations
☐ Fainting spells

Gastrointestinal ☐ None of the below

☐ Nausea / Vomiting
☐ Constipation
☐ Diarrhea
☐ Heartburn / Indigestion
☐ Abdominal pain
☐ Blood in stool

Genitourinary ☐ None of the below

☐ Pain or burning with urination
☐ Blood in urine
☐ Sexual dysfunction / impotence
☐ Frequent urination
☐ Change in menstrual cycle

Neurologic ☐ None of the below

☐ Headache
☐ Numbness / Tingling
☐ Involuntary movements / tremor / twitching / cramps
☐ Memory loss
☐ Poor balance / falls
☐ Seizures / Convulsions

Psychiatric ☐ None of the below

☐ Mood change
☐ Depression
☐ Anxiety
☐ Hallucinations
☐ Paranoia
☐ Delusions

Endocrine ☐ None of the below

☐ Heat or cold intolerance
☐ Excessive sweating
☐ Excessive thirst / urination
☐ Hair change

Hematologic/Immune ☐ None of the below

☐ Easy bruising or bleeding
☐ Swollen lymph nodes

Musculoskeletal ☐ None of the below

☐ Joint pain
☐ Neck pain +/- shooting pain into arms
☐ Low-back pain +/- shooting pain into legs

Epilepsy Questionnaire

How long have you had seizures?_____

Date of first seizure:_____ Date of last seizure:_____

How often do you have seizures?_____

Have you ever been hospitalized because of seizures? *(circle one)* **Yes** **No**

If yes, please provide details regarding dates, duration of stay, and treatment received:_____

_____

Risk factors for seizures: *(check if yes)*

□ Birth Injury □ Head Injury
□ Febrile Seizure □ Stroke
□ Prior Neurosurgery

If you answered yes to any of the above, please explain:_____

_____

Please indicate type of seizures and frequency:

	Frequency/Week		**Frequency/Week**
Simple Partial	_____	Absence (staring spells)	_____
Complex Partial (petit mal)	_____	Atonic (drop seizure)	_____
Generalized Tonic-Clonic (grand mal)	_____	Tonic (stiffening seizure)	_____
Myoclonic (jerks)	_____	Other type:_____	_____

Can you tell if you are about to have a seizure? *(circle one)* **Yes** **No**

If yes, please explain:_____

_____

Please describe details of your symptoms when you have a seizure:_____

_____

Please list all seizure medications you have tried previously:_____

_____

If you have any side effects to previous seizure medications, please explain:_____

_____

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

0 = would *never* doze

1 = *slight* chance of dozing

2 = *moderate* chance of dozing

3 = *high* chance of dozing

Situation	Score
Sitting and reading	
Watching TV	
Sitting inactive in public (e.g., theater)	
Passenger in a car for 1 hour	
Lying down to rest in the afternoon	
Sitting and talking to someone	
Sitting quietly after lunch (no alcohol)	
In a car, stopped in traffic	
Total Score:	

Do you:

	Never	Occasionally	Often	Always
Fall asleep or get sleepy when:				
Driving?	0	1	2	3
At work?	0	1	2	3
Do you take intentional naps?	0	1	2	3
Do you experience periods of muscle weakness or loss of muscle control with laughter or excitement?	0	1	2	3
Do you experience vivid dreamlike episodes when falling asleep?	0	1	2	3
Do you feel unable to move when falling asleep?	0	1	2	3