THE Portland Clinic®

Department of Neurology

New Patient Seizure History

FIRST NAME: _____ **LAST NAME:** _____

DATE OF BIRTH: _____ **PRIMARY CARE PROVIDER & CLINIC:** _____

PREVIOUS NEUROLOGIST: _____

MY GOALS FOR THIS VISIT ARE:

_____

_____

_____

_____

DO YOU HAVE ANY QUESTIONS FOR THE DOCTOR TODAY?

Please list below:

1. _____

2. _____

3. _____

4. _____

SEIZURE HISTORY:

1. At what age did you have your very first seizure(s)? _____ year(s) old.

2. Describe the very first seizure you had and what caused it, if known.

_____

_____

_____

Neurology Locations
[11009 8/14]

The Portland Clinic - South
6640 SW Redwood Lane
Portland, OR 97224
(503) 620-7358

The Portland Clinic - Downtown
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(503) 221-0161

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SEIZURE HISTORY CONTINUED:

3. Please describe your currrent seizure activity and how often these events occur.

4. How do you feel after seizures (tired, confused, back to normal, etc.) and how long do symptoms last?

	Yes	No
Do you ever wake up in the morning with a sore tongue?	☐	☐
Do you ever wake up in the morning with urinary incontinence?	☐	☐
Do you have any warnings or any feelings that you are going to have a seizure?	☐	☐

Please explain: _____

HANDEDNESS:

Are you *(circle one)*: Left Handed Right Handed

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RISK FACTORS:

1. Birth History:

a. How were you born? *(circle one)* Normal vaginal Vaginal delivery w/forceps C-section

	Yes	No
b. Any complications after birth?	☐	☐
c. Any seizures immediately after birth?	☐	☐
d. Difficulty breathing or latching?	☐	☐
e. Jaundice after birth?	☐	☐

2. Do you have any history of:

a. Cerebral palsy	☐	☐
b. Meningitis or encephalitis	☐	☐
c. Febrile seizures (fever related)	☐	☐
d. Staring spells / lost time	☐	☐
e. Head trauma	☐	☐
f. Fainting	☐	☐

g. Other _____

MEDICATION HISTORY

Please list all **MEDICATIONS** you take routinely, prescribed or over-the-counter, along with the dosages:
(If you are a Portland Clinic patient and our list is up to date leave blank)

Medication:	Dose:	Frequency:

Please list all allergies and sensitivities (e.g. medications, foods, latex, iodine, etc.)

_____

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PAST ANTI-EPILEPTIC DRUGS (AED's):

Name ALL epilepsy medications you have tried in the past, not including current ones. Please indicate the reason for discontinuation, blood levels or highest dosage tried (if you can remember).

Seizure medication:	Reason for discontinuation:	Highest dose and/or blood levels:

Here is a quick reference of possible epilepsy medications (can circle if you have taken it):

Acustat
Activan
Carbamazepine
Carbatrol
Celontin
Clobazam
Clonazepam
Clorazepate
Depakote
Depakote ER
Diastat
Diazepam
Dilantin
Ethosuximide
Felbamate
Frizium
Gabapentin
Gabitril
Keppra
Klonopin
Lacosamide
Lamictal
Lamotrigine
Levetiracetam
Lorazepam
Lyrica
Methosuximide
Mysoline
Neurontin
Onfi
Oxcarbazepine
Phenobarbital
Phenytek
Phenytoin
Pregabalin
Primidone
Sodium Valproate
Tegretol
Tegretol XR
Tiagabine
Toprimate
Topamax
Tranxene
Trileptal
Valium
Valproic Acid
Vimpat
Zarontin
Zonegran
Zonisamide

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PAST MEDICAL HISTORY:

Have you had or do you have any of the following conditions?

	Yes	No
Alcoholism	☐	☐
Arthritis	☐	☐
Asthma	☐	☐
Cancer	☐	☐
Chest Pain	☐	☐
Colitis	☐	☐
Depression / Anxiety	☐	☐
Diabetes	☐	☐
Drug Addiction	☐	☐
Emphysema	☐	☐
Frequent Kidney Infections	☐	☐
Frequent Bladder Infections	☐	☐
Gallbladder disease	☐	☐
Gout	☐	☐

	Yes	No
High Blood Pressure	☐	☐
Headache	☐	☐
Hepatitis	☐	☐
Heart Attack	☐	☐
Jaundice	☐	☐
Kidney Disease	☐	☐
Other Heart Disease	☐	☐
Pain (Chronic)	☐	☐
Rheumatic Fever	☐	☐
Stomach Ulcers	☐	☐
Thyroid Disease	☐	☐
Trouble Sleeping	☐	☐
Suicidal Thoughts	☐	☐
Other _____		

SURGERIES:

(List procedure and approximate year)

Procedure	Year	Procedure	Year

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SEIZURE WORK UP:

Have you had any **MRIs, CT scans, EEGs, VEEGs, PETs, Craniotomy Workup and/or Tests**?
If yes, list where and when these were done.

Type of Scan:	Where / When:

FAMILY HISTORY:

Do any of your blood relatives currently have, or have had in the past, any of the following? Enter the relationship as well:

	Yes	No	Relative(s)
Epilepsy or seizure	☐	☐	
Migraine	☐	☐	
Suicide	☐	☐	
Febrile, infantile or childhood seizures	☐	☐	
Mental retardation	☐	☐	
Kidney stones	☐	☐	
Stroke	☐	☐	
Cancer (which type) _____	☐	☐	
Brain Tumor	☐	☐	
High blood pressure	☐	☐	

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PERSONAL HABITS:

Do you drink alcohol? Yes ____ No ____

If yes: Regularly ____ Socially ____

Hard liquor ☐ 1-3 oz per day ____ over 3 oz per day ____

Beer ☐ 1 bottle/can per day ____ 2 bottles/cans per day ____ 3 or more bottles/cans per day ____

Wine ☐ 1-2 glasses per day ____ 3-5 glasses per day ____ more than 5 glasses per day ____

Do you consume more than 5 drinks within a 24 hour period? Yes ____ No ____

How many days in the last 6 months did you consume more than 5 drinks in a 24 hour period? _____

Do you smoke? Yes ____ No ____

Have you smoked in the past? Yes ____ No ____

Do you or have you used recreational / illicit drugs? Yes ____ No ____

If yes, what have you used? _____

_____

When did you last use above substance? _____

Do you drink caffeinated drinks? Yes ____ No ____

If yes, list how many per day of the following: _____ Coffee; _____ Tea; _____ Soda; _____ Energy Drinks

DRIVING:

Do you drive? Yes ____ No ____

Have you ever had an accident due to a seizure? Yes ____ No ____

Are you afraid to drive? Yes ____ No ____

If you do not drive now, why not?

_____

_____

_____

_____

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CURRENT SYMPTOMS - IN THE LAST 6 MONTHS: (please mark all that apply)

1. Head, Eyes, Ears, Nose, Throat, Lymph Nodes:

- ___ Headaches
- ___ Double vision
- ___ Hoarseness of voice
- ___ Tinnitus (buzzing or humming)
- ___ Photophobia (light bothers eyes)
- ___ Swollen and/or painful lymph nodes
- ___ Head trauma
- ___ Deafness
- ___ Neck swelling
- ___ Pain and/or drainage from ears
- ___ Nasal and/or sinus congestion
- ___ Visual loss or change
- ___ Nose bleeds
- ___ Neck stiffness
- ___ Sneezing
- ___ Sore throat
- ___ Glaucoma
- ___ Teethe grinding / clenching
- ___ Headaches
- ___ Hearing problems
- ___ Vision problems
- ___ Dental problems
- ___ Sinus problems

2. Respiratory System:

- ___ Shortness of breath
- ___ Sputum/secretion production
- ___ Wheezing
- ___ Cough
- ___ Hemoptysis
- ___ Breathing difficulty

3. Cardiovascular System:

- ___ Chest pain, discomfort, heaviness, tightness
- ___ Shortness of breath with exertion
- ___ PND (waking up short of breath)
- ___ Orthopnea (sleeping on two or more pillows)
- ___ Leg swelling
- ___ High blood pressure
- ___ Palpitations
- ___ Chest pain
- ___ Heartburn

4. Gastrointestinal System:

- ___ Anorexia (poor appetite)
- ___ Nausea and/or vomiting
- ___ Constipation or diarrhea
- ___ Weight loss or gain
- ___ Hematochezia (red blood in bowel movements)
- ___ Melena (black bowel movements)
- ___ Jaundice
- ___ Abdominal pain
- ___ Dysphagia (difficulty swollowing)
- ___ Stomach pain
- ___ Weight change:
  loss _____ lbs , gain_____lbs

5. Genitourinary System:

- ___ Hematuria
- ___ Oliguria (infrequent urination)
- ___ Incontinence
- ___ Heavy menstrual flow
- ___ Polyuria (urination of large volumes of urnie)
- ___ Nocturia (urination at night)
- ___ Frequency (frequent urination)
- ___ Pyuria (cloudy urine)
- ___ Urgency (sensation to urinate)
- ___ Sexual dysfunction
- ___ Symptoms of menopause
- ___ Irregular periods
- ___ PMS
- ___ Bladder problems
- ___ Excessive urination or thirst

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6. Nervous system:

- ___ Weakness/paralysis one side of body
- ___ Urinary and/or fecal incontinence (wet or soil underwear)
- ___ Memory loss, sleep disturbance, mood disorders (anxiety, depression)
- ___ Insomnia
- ___ Daytime sleepiness
- ___ Snoring
- ___ Sleep apnea
- ___ Seizures / shaking
- ___ Numbness
- ___ Loss of consciousness
- ___ Dizziness

7. Musculoskeletal System:

- ___ Joint pain / swelling / redness
- ___ Muscle aches and pains
- ___ Back pain
- ___ Neck pain
- ___ Leg / foot cramps
- ___ Leg restlessness
- ___ Weakness

8. Dermatological System:

- ___ Rash
- ___ Mole changes
- ___ Pigmentation (change in color)
- ___ Breast pain
- ___ Pruritus (itching)
- ___ Breast lumps
- ___ Bleeding or bruising
- ___ Changes in nipples
- ___ Breast lumps / discharge
- ___ Allergic reaction
- ___ Change in skin / hair

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