UCSF Epilepsy Center

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NEW PATIENT SCREENING QUESTIONNAIRE

In order to provide you with more effective medical care, the Epilepsy Center staff needs certain basic information about your medical and social history and mood.

Please be aware that the physician may be legally obligated to report your case to the Department of Health, which then forwards the case to the Department of Motor Vehicles.

Name of Patient ____

Name of Person Completing Questionnaire _________________________

Relationship to Patient ____

Date Questionnaire Completed ___________________________________

Doctor who referred you to the Epilepsy Center:

Name: ____

Address: ______________________________________

Phone#: _______________________________________

PAST MEDICAL HISTORY

Have you ever had any of the following medical problems:			Comments:
Stroke	Yes ____	No ____	____________________
Dementia	Yes ____	No ____	____________________
Learning disability or Need for special education	Yes ____	No ____	____________________
Seizures related to fever as a baby	Yes ____	No ____	____________________
Head trauma	Yes ____	No ____	____________________
Brain infection	Yes ____	No ____	____________________
Blood disorder	Yes ____	No ____	____________________
Liver disease	Yes ____	No ____	____________________
Heart problems	Yes ____	No ____	____________________
Cancer/tumor	Yes ____	No ____	____________________
Kidney disease	Yes ____	No ____	____________________
Diabetes	Yes ____	No ____	____________________
Emotional Illness	Yes ____	No ____	____________________
Migraine headaches	Yes ____	No ____	____________________

FAMILY HISTORY

Is there a history of seizure disorder on either side of the patient's family? Yes ____ No ____

If yes, provide the relationship of the person(s) to the patient:________________

SOCIAL HISTORY

If you work, what do you do? ____

Are you currently attending school? Yes ____ No ____If yes, what grade? _____________

Do you drink alcohol/how much per week? ________

Do you smoke tobacco? ____ How many packs per day? ____ For how many years? ______

Have you used recreational drugs? ______If so, what type (i.e., marijuana, cocaine, amphetamines)____

Do you use herbal medications or supplements? If so, what type? ________________

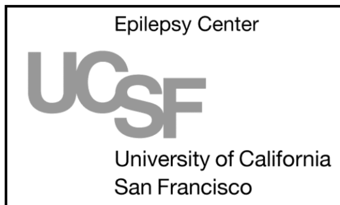
How many hours do you sleep each night? ______________________

Do you have a valid driver's license? _____Are you presently driving? _____

Have you ever been reported to the Department of Motor Vehicles because of seizures or loss of awareness? ________________

Are you pregnant? Yes ____ No ____ If yes, what week of the pregnancy? _____________

If no, when was your last menstrual period? _____________



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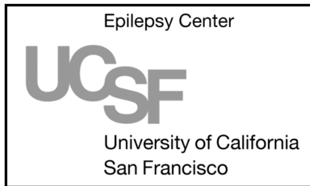
Antiseizure Medication Record

Patient name:______________________________________

Allergies: _____________________ **Describe reaction:**_______________________

Medication **Tradename (generic)**	***Tried?***	***Dates***	***Reason discontinued or Comments***
Ativan (lorazepam)			
Banzel (rufinamide)			
Carbatrol (carbamazepine)			
Depakote (valproic acid, divalproex sodium)			
Diamox (acetazolamide)			
Diastat/Valium (diazepam)			
Dilantin (phenytoin)			
Felbatol (felbamate)			
Fycompa (perampanel)			
Gabitril (tiagabine)			
Keppra (levetiracetam)			
Klonopin (clonazepam)			
Lamictal (lamotrigine)			
Lyrica (pregabalin)			
Mysoline (primidone)			
Onfi (clobazam)			
Phenobarbital			
Potiga (ezogabine)			
Neurontin (gabapentin)			
Sabril (vigabatrin)			
Tegretol/Tegretol XR (carbamazepine)			
Topamax (topiramate)			
Tranxene (clorazepate)			
Trileptal (oxcarbazepine)			
Vimpat (Lacosamide)			
Zarontin (ethosuximide)			

Zonegran (zonisamide)			



Neurological Disorders Depression Inventory in Epilepsy (NDDI-E)

Name: ____________________________Date: ______________

For the statements below, please circle the number that best describes you over the *last two weeks including today.*

	Always or Often	**Sometimes**	**Rarely**	**Never**
Everything is a struggle	4	3	2	1
Nothing I do is right	4	3	2	1
Feel guilty	4	3	2	1
I'd be better off dead	4	3	2	1
Frustrated	4	3	2	1
Difficulty finding pleasure	4	3	2	1

Review of Symptoms

Name: ____________________ **Date:** _______________

Have you experienced problems with any of the following symptoms?

Symptom	Yes	No	Don't know
Weight gain			
Weight loss			
Intolerance to cold or heat			
Sweats			
Shortness of breath			
Chest pain			
Palpitations			
Nausea			
Vomiting			
Constipation			
Diarrhea			
Swollen joints			
Headaches			
Hair loss			
Problems with skin/rash			
Unsteadiness			
Dizziness			
Double vision/blurred vision			
Tiredness or sleepiness			
Nervousness or agitation			
Feelings of aggression			
Depression			
Memory problems			
Problems finding the right word while talking			

Disturbed sleep			

SEIZURE DIARY

Name____

Seizure Type

1:____

2:____

3.____

Month 1

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Indicate on calendar the type of seizure (i.e. type #1, #2 or #3) and how many you had.

Medications for Month 1

Medication:	Tablet size (milligrams)	Tablets/day

Month 2						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Medications for Month 2 (if same medications and dosing as Month 1, indicate so)

Medication:	Tablet size (milligrams)	Tablets/day

Month 3						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Medications for Month 3 (if same medications and dosages as Months 1&2, indicate so)

Medication:	Tablet size (milligrams)	Tablets/day