Name:______________________
DOB:______________________

JOHNS HOPKINS EPILEPSY CENTER
PATIENT HISTORY QUESTIONNAIRE

Date___________________________ Physician: Dr. Ronald Lesser

Patient Name______________________ Date of Visit:____________________

Dear Patient:

Welcome to the Johns Hopkins Epilepsy Center and the Department of Neurology at Johns Hopkins University. This questionnaire will allow the doctor to get to know more about you, your medical condition, your family and your habits. **We ask that you fill this form out prior to your visit.** Ideally, you should send the completed form at least a week ahead of time so that Dr. Lesser can review it prior to your visit. If you do not send it, you should give the completed form to the person who registers you at the clinic. This questionnaire is confidential and will be kept as part of your medical record. **Also, if you have had a CT Scan, MRI or EEG before, please obtain the actual studies (that is, the films or tracings), not just the written reports**. These also should be sent ahead of time, if possible, or otherwise brought with you to the appointment.

NAME, ADDRESS, PHONE NUMBER, AND SPECIALTY OF THE DOCTOR THAT SENT YOU HERE (IF APPLICABLE):

FULL NAME:____
ADDRESS:____
PHONE:_________________________ FAX:____________________________
SPECIALTY:______________________

IF YOU WERE NOT SENT HERE BY A DOCTOR, WHO SENT YOU? __________________

PLEASE LIST ALL OF THE DOCTORS WHO SHOULD RECEIVE A COPY OF YOUR REPORT:

1) Primary Care Physician: _______________

ADDRESS:__________________________
____
PHONE:(____)______________________

2)NAME:_____________________________

ADDRESS:__________________________
____
PHONE:(____)______________________

3)NAME:_____________________________

ADDRESS:__________________________
____
PHONE:(____)______________________

4)NAME:_____________________________

ADDRESS:__________________________
____
PHONE:(____)______________________

Name:______________________
DOB:______________________

History of Present Illness:

Briefly describe the reason for your visit.

1) What types of symptoms are you experiencing? What are the episodes like? If your problem occurs in more than one way, describe each way it occurs. Use another piece of paper if necessary.

2) What part (where) of the body does the problem affect? Is there any change in what you see, hear, taste, or smell when the problem occurs? Are there any other sensations that occur along with or as a part of this problem?

3) How severe is the problem and are the symptoms?

4) When did the problem begin? How often is it occurring now? (for instance, 1-2 times a month)

5) How long do the symptoms last each time?

6) Does anything seem to cause the problem to occur? Does it occur at any particular time of day?
Yes No If so, What, When?

7) Does anything help make the problem go away or get better? Yes No If Yes, What?

8) Was there a cause for your episodes, such as an injury, or meningitis or another infection? If so, please describe.

9) Are there any other symptoms that seem to occur along with your problem, for example just before or just after an episode occurs? Do you have a warning before episodes?

Name:______________________
DOB:______________________

Please list all of the medicines you are TAKING NOW. Include over the counter medicines, vitamins and herbal preparations.

MEDICATIONS (include over-the-counter medicines, vitamins and herbal preparations)	DOSE (e.g., strength, # of pills or drops)	ROUTE (e.g., by mouth, injection, inhaled, rectally, on skin)	FREQUENCY AND NUMBER OF PILLS, DROPS, ETC. EACH TIME (list the times you take each, and also how much each time)
Example: Vitamin C	*500 mg*	*By mouth*	*One pill at 7:00 AM*
1.			
2.			
3.			
4.			
5			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			

Name:______________________
DOB:______________________

Drug allergies

Please list drugs to which you are allergic. List any other allergies that you have. Indicate what kind of allergy you have with each. **Use the back or another piece of paper if necessary.**

____

____

____

____

Please list each medicine you have tried **in the past** for the problem which led to this appointment. If possible, list them in the order in which they were tried. For each, indicate name, maximum dose taken, maximum blood level (if known) and side effects if any. **Use the back or another piece of paper if necessary.**

1.______________________________ 6.______________________________

2.______________________________ 7.______________________________

3.______________________________ 8.______________________________

4______________________________ 9.______________________________

5.______________________________ 10.______________________________

Past Medical History:

Please list all operations you have had in the past with approximate dates.

1.______________________________ 6.______________________________

2.______________________________ 7.______________________________

3.______________________________ 8.______________________________

4.______________________________ 9.______________________________

5.______________________________ 10.______________________________

HAVE YOU EVER HAD A PROBLEM WITH ANESTHESIA? Yes No (circle one) IF SO, WHEN? WHAT HAPPENED?

Name:______________________
DOB:______________________

Please list all other current medical problems as well as major illnesses you have had in the past with approximate dates.

1.________________________________ 6.________________________________

2.________________________________ 7.________________________________

3.________________________________ 8.________________________________

4.________________________________ 9.________________________________

5.________________________________ 10.________________________________

Current weight__________________ Current height__________________________

Have you ever had a blood transfusion? Yes No

If yes, Why?____

____

(Women Only)

Last menstrual period___________Are you post-menopausal? Yes No If so, date__________

Date of last gynecological exam with pap result___________________________________

Date of last mammogram and result____

Have you ever been pregnant? Yes No If so, how many times? ______________________

How many deliveries have you had?____

Have you ever had a miscarriage? Yes No Have you ever had an abortion? Yes No

Name:______________________
DOB:______________________

Review of Systems:

Please circle and provide brief detail for the medical conditions below which apply to you either now or in the past.

CONSTITUTIONAL
Weight loss
Weight gain
Change in appetite
Altered taste
Altered smell
Excessive sleepiness
Unable to sleep
Fatigue
Fever

EYES
Blurred vision
Double vision
Glaucoma
Cataracts

RESPIRATORY
Emphysema
Chronic cough
Tuberculosis
Asthma
Bronchitis

CARDIO-VASCULAR
Chest pain
Chest pressure
Angina
Fainting
Leg swelling
High blood pressure
Low blood pressure
Shortness of breath

EARS, NOSE,MOUTH,THROAT
Hearing loss
Ringing in ears
Nose bleeds
Nose discharge
Sore throat
Trouble breathing through nose
Sinus disease
Mouth sores
Mouth growths
Ear sores
Ear growths
Trouble swallowing

GASTROINTESTINAL
Abdominal pain
Constipation
Diarrhea
Rectal bleeding
Vomiting
Hepatitis

INTEGUMENTARY
Skin rash
Breast disease
Birthmarks

GENITOURINARY
Blood in urine
Frequent urination
Urinary urgency
Urinary pain
Urinary incontinence
Impotence
Sexual dysfunction
Venereal disease
Vaginal bleeding
Kidney disease
Bladder infections
Kidney infections

ENDOCRINE
Diabetes
Thyroid Disease

ALLERGY/IMM
AIDS
HIV
Allergies - Drug (specify next page)
Allergies - Food, Environment, Other

MUSCULOSKELETAL
Low back pain
Neck pain
Joint pain
Muscle pain
Muscle soreness
Lupus erythematosus
Arthritis

BLOOD-LYMPHATIC
Blood disorder
Enlarged lymph nodes
Easy bleeding
Easy bruising

PSYCHOLOGICAL
Depression
Anxiety
Trouble concentrating
Psychosis

NEUROLOGICAL
Headache
Dizziness
Concussion
Memory loss
Weakness
Tingling
Falls
Trouble walking
Trouble with balance
Numbness

Are you Left Handed or Right Handed (Circle one)

Name:______________________
DOB:______________________

Family History:

Please list all medical problems and current age of the following family members. If any are deceased, please list cause and approximate age of death.

GRANDPARENTS: 1)____

2)____

3)____

4)____

FATHER____

MOTHER____

BROTHERS (List name, age, occupation & medical history)____________________

____

SISTERS (List name, age, occupation & medical history)____________________

____

CHILDREN (List name, age, occupation & medical history)____________________

____

GRANDCHILDREN (List name, age, occupation & medical history)____________________

Does anyone in your family have seizures? If so, who?____________________

____

Name:______________________
DOB:______________________

Social History:

Please circle your highest level of education:

Grade school High School Vocational School College Graduate School

Did you graduate from your highest level of education? Yes No.

If no, how many years did you have of your highest level of education?

Where do you work? (If retired list most recent place of employment and date of retirement)

____

What is your position there?____

Are you Single / Married / Divorced / Separated (Circle One)

Spouse's occupation ____

Current living arrangement ____

Hobbies____

Do you smoke? Yes No If you smoked and quit, date you quit________________________

If you smoke, how many packs per day?______________

Do you drink alcohol? Yes No (Circle One) If you drank and quit, date you quit____________

If you drink alcohol, approximately how many drinks per week? ____________

Have you ever had a problem with alcohol or drugs?________________________________

Thank you for taking the time to fill this out.
Please bring this with you to your appointment.
Do Not Mail This Form Back
If you have had an EEG or MRI, please send them ahead of time before the appointment.
If you cannot send them ahead of time please bring with you to appointment.

Name:______________________
DOB:______________________

FAMILY HISTORY							
	Father	Mother	Father's Parents	Mother's Parents	Brothers / Sisters	Children	NOTES
Arthritis							
Bleeding disorder							
Cancer							
CNS Tumors							
Dementia							
Diabetes							
Epilepsy							
Heart Disease							
Hypertension							
Kidney Disease							
Lupus							
MS							
Neuropathy/ALS/muscular dystrophy							
Stroke							
Thyroid Disease							

Does anyone else in your family have seizures? If so,

who?____

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