LABEL PLEASE

Dr. Tadeu (Tad) Fantaneanu

EPILEPSY CLINIC NEW PATIENT INTAKE FORM

To help us better understand your condition, we kindly ask that you complete the following questions. Thank you!

General information

Who is your primary care provider (GP or general practitioner)?_____

Who referred you for this appointment?_____

Are you currently driving? Yes No

If you currently smoke cigarettes, how many do you smoke per day?_____pack/day

If you do not smoke now, how much did you smoke in the past?_____pack/day

Do you drink alcohol? Yes No if yes,_____drinks/week

Do you use any street drugs? Yes No

Are you currently pregnant? Yes No

Seizure/ Epilepsy information

Which is your dominant hand for writing? Right Left

How many different types of seizures do you currently have (if this applies to you)?_____

Does anyone in your family have a history of seizures or epilepsy? Yes No

If yes, who does? :_____

Have you ever been diagnosed with the following:

1. A traumatic brain injury where you lost consciousness (eg. from a motor vehicle accident)? Y N
2. A brain infection like meningitis or encephalitis? Y N
3. A convulsion in the setting of high fevers, before the age of 6 years old? Y N
4. A brain tumor? Y N
5. A stroke? Y N

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Please provide a complete list of your MEDICATIONS (if you are taking any):

Medication name	Current dose	Time you take them	Side effects

List below if not enough space

Do you have any medication allergies (if yes, list them)?_____

For women only:

Do you take folic acid? Yes No Are you using birth control? Yes No

*Which pharmacy do you use (Name, street and nearest intersection if you don't have the address handy)?

_____

Other medical history

Have you been diagnosed with any other medical conditions (eg. conditions for which a doctor may have prescribed medications in the past)?

Please list below	

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Screening Questionnaires

Mental Health

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Worrying too much about different things	0	1	2	3
Trouble relaxing	0	1	2	3
Being so restless that it's hard to sit still	0	1	2	3
Becoming easily annoyed or irritable	0	1	2	3
Feeling afraid as if something awful might happen	0	1	2	3

Total Score (*staff will complete this*)				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____ Somewhat difficult _____ Very difficult _____

Extremely difficult _____

	Always or often	Sometimes	Rarely	Never
Everything I do 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