Name (Last, First M.I.)

Date of Birth (Month/Day/Year)

Today's Date

Health History Questionnaire

If you have completed sections 1-4 since your last birthday, please proceed to section 5. **Check all that apply.**

1. Medical History

- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Blood Clots/DVT
- ☐ Cancer
- ☐ CHF/Heart Failure
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema/COPD
- ☐ GERD/Heartburn/ Acid Reflux
- ☐ Heart Disease
- ☐ HIV/AIDS
- ☐ Hypertension/High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Palpitations/Racing Heart
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Other ______________

2. Surgical History

- ☐ No surgery
- ☐ Anesthesia Complications
- ☐ Appendectomy
- ☐ Breast surgery
- ☐ Colonoscopy
- ☐ Coronary Artery Bypass
- ☐ Coronary Artery Stent
- ☐ Eye Surgery
- ☐ Gallbladder Surgery (Cholecystectomy)
- ☐ Hernia repair

  Location ______________
- ☐ Hysterectomy
- ☐ Joint Replacement
- ☐ Prostate Surgery
- ☐ Spine Surgery
- ☐ Organ Transplant
- ☐ Other ______________

3. Social History

Alcohol Use

☐ Yes ☐ No ☐ Never

☐ Wine

☐ Beer

☐ Liquor

Drinks per Week ________

Street Drug Use

☐ Yes ☐ No ☐ Never

☐ Marijuana

☐ Methamphetamines

☐ Cocaine

☐ Heroin

☐ Other

Tobacco Use

☐ Yes ☐ No ☐ Never

Type ______________

☐ Current Smoker

Packs per day _____

☐ Former Smoker

Packs per day _____

Sexually Active

☐ Yes ☐ No

☐ Not Currently

Partners

Check all that apply

☐ Female ☐ Male

Birth Control / Protection

☐ Yes ☐ No

Method ______________

4. Family Medical History Check all that apply.

☐ I have no family history

☐ I have unknown family history

Relationship	Anemia	Anxiety	Arthritis	Asthma	Bleeding Disorder	Blood Clots /DVT	Cancer	CHF/Heart Failure	Depression	Diabetes	Emphysema/COPD	GERD/Heartburn/Acid Reflux	Heart Disease	HIV/AIDS	High Blood Pressure	Kidney Disease	Liver Disease	Palpitations/Racing Heart	Seizures	Stroke	Thyroid Problems	Other
Father																						
Mother																						
Sibling																						
Maternal Grandmother																						
Maternal Grandfather																						
Paternal Grandmother																						
Paternal Grandfather																						
Other																						

see reverse side

Name (Last, First M.I.) ______________________

Date of Birth (Month/Day/Year) ______________________

Health History Questionnaire

If you have completed sections 1-4 since your last birthday, please proceed to section 5.

5. Strong Epilepsy Center

With which hand do you write? ☐ Left ☐ Right ☐ Ambidextrous

Seizures:

At what age did you have your first seizure? ____________

Describe your first seizure ______________________

Was there any known reason for your first seizure? ☐ Yes ☐ No Describe ______________________

At what age did you have your next seizure? ______________________

How many different types of seizures do you have? ______________________

Describe your current seizure(s) ______________________

Do you have a warning before your seizures? ☐ Yes ☐ No Describe ______________________

How long does it take for you to return to normal after a seizure? ______________________

When was your most recent seizure? ______________________

How often do your current seizures occur? ______________________

How do the seizures affect your everyday life? ______________________

When was the last time you were in emergency or admitted to a hospital for your seizures? ____________

Why? ______________________

Are your seizures related to your menstrual cycle? ☐ Yes ☐ No ☐ Not Applicable

Did you have a childhood febrile convulsion (seizure with fever age 5 or younger)? ☐ Yes ☐ No ☐ Unknown

Did you ever have a head injury with loss of consciousness: ☐ Yes ☐ No Describe ______________________

Did you ever have a brain infection (meningitis or encephalitis) ☐ Yes ☐ No Describe ______________________

Do you have any birthmarks? ☐ Yes ☐ No Describe ______________________

Were you ever treated for depression, anxiety or other mental health problems: ☐ Yes ☐ No

Were you ever the victim of abuse: ☐ Emotional ☐ Physical ☐ Sexual ☐ None

List your current mental health providers

Counselor ______________________ Psychiatrist ______________________ ☐ None

Were you ever told you have Epilepsy? ☐ Yes ☐ No Type ______________________

Name (Last, First M.I.) ______________________

Date of Birth (Month/Day/Year) ______________________

Health History Questionnaire

5. Strong Epilepsy Center

Anti-Seizure Medications:

Check all that you take presently or have taken in the past.

If you took the medication in the past, check the box and explain why you stopped.

- ☐ acetazolamide (Diamox) ☐ Past/Why stopped? ______________
- ☐ cannabidiol (Epidiolex) ☐ Past/Why stopped? ______________
- ☐ carbamazepine (Tegretol, Carbatrol) ☐ Past/Why stopped? ______________
- ☐ chlorazepate (Tranxene) ☐ Past/Why stopped? ______________
- ☐ clobazarn (Onfi, Frisium) ☐ Past/Why stopped? ______________
- ☐ clonazepam (Klonopin) ☐ Past/Why stopped? ______________
- ☐ diazepam (Valium) ☐ Past/Why stopped? ______________
- ☐ eslicarbazepine (Aptiom) ☐ Past/Why stopped? ______________
- ☐ ethosuximide (Zarontin) ☐ Past/Why stopped? ______________
- ☐ ezogabine (Potiga) ☐ Past/Why stopped? ______________
- ☐ felbarnate (Felbatol) ☐ Past/Why stopped? ______________
- ☐ gabapentin (Neurontin) ☐ Past/Why stopped? ______________
- ☐ lacosamide (Vimpat) ☐ Past/Why stopped? ______________
- ☐ lamotrigine (Lamictal) ☐ Past/Why stopped? ______________
- ☐ levetiracetam (Keppra) ☐ Past/Why stopped? ______________
- ☐ lorazepam (Ativan) ☐ Past/Why stopped? ______________
- ☐ oxcarbazepine (Trileptal) ☐ Past/Why stopped? ______________
- ☐ phenobarbital ☐ Past/Why stopped? ______________
- ☐ phenytoin (DiLantin/Phenytek) ☐ Past/Why stopped? ______________
- ☐ perampanel (Fycompa ☐ Past/Why stopped? ______________
- ☐ pregabalin (Lyrica) ☐ Past/Why stopped? ______________
- ☐ primidone (Mysoline) ☐ Past/Why stopped? ______________
- ☐ rufinamide (Banzel) ☐ Past/Why stopped? ______________
- ☐ stiripentol (Diacornit) ☐ Past/Why stopped? ______________
- ☐ tiagabine (Gabitril) ☐ Past/Why stopped? ______________
- ☐ topiramate (Topamax) ☐ Past/Why stopped? ______________
- ☐ valproic acid (Depakote, Depakene) ☐ Past/Why stopped? ______________
- ☐ vigabatrin (Sabril) ☐ Past/Why stopped? ______________
- ☐ zonisamide (Zonegran) ☐ Past/Why stopped? ______________
- ☐ other ☐ Past/Why stopped? ______________

What was your first anti-seizure medication and when was it started? ______________________

Which anti-seizure medicine(s) did you like best and why? ______________________

Which anti-seizure medicine(s) was your least favorite and why? ______________________

Do you have any side effects from your current medications? ☐ Yes ☐ No Describe

When was the last time you missed any of the anti-seizure medicines? ______________________

Do you have a Vagal Nerve Stimulator (VNS)? ☐ Yes ☐ No

Do you have a NeuroPace Responsive NeuroStimulator (RNS)? ☐ Yes ☐ No