

COLUMBIA COMPREHENSIVE EPILEPSY/SLEEP CENTER

NEW PATIENT INFORMATION SHEET

Please fill out the following form to help your physician provide the best possible care.

Name: _____ Date: _____

Date of birth: _____ Age: _____ Gender: _____ Height: _____ Weight: _____

Handedness: right-handed left-handed ambidextrous

Home Address: _____

Home phone #: _____ Work phone #: _____

Referring physician (name and specialty): _____

Address: _____

Phone: _____

Please list all your other current physicians (name, specialty, address, phone):

PLEASE LEAVE THE RIGHT HAND PORTION OF THIS FORM BLANK FOR PHYSICIAN USE.

PAST MEDICAL HISTORY: Do you have or have you had any of the following medical conditions? Provide details below if necessary.

	Yes	No		Yes	No
High blood pressure			Stroke or TIA		
High cholesterol			Alzheimer's or other memory disorder		
Heart disease (angina, heart attack, arrhythmia)			Parkinson's or other movement disorder		
Lung disease (emphysema, COPD, asthma...)			Chronic tremor		
Kidney disease or other urological disorder			Migraines		
Liver disease (cirrhosis, hepatitis ...)			Cancer		
Gastrointestinal disease (colitis, ulcer, bleeding...)			Chronic menstrual disorder		
Chronic skin condition (psoriasis...)			Immunologic disorder (rheumatoid arthritis, lupus...)		
Loss of Hearing			Chronic allergies/hay fever		
Recurrent vertigo			Hematological disorder (sickle cell, hemophilia...)		
Visual loss			Tuberculosis		
Glaucoma			HIV or AIDS		
Diabetes			Encephalitis or meningitis		
Thyroid condition			Head trauma w/ loss of consciousness		
Depression			Seizure with high fever as a baby or young child		
Psychiatric illness other than depression (bipolar, schizophrenia.)			Attention deficit/hyperactivity disorder (ADHD)		
Seizures			Fainting or blackouts		

Please list any **other chronic medical illnesses, hospitalizations or surgeries**, and provide details of above conditions.

REVIEW OF SYMPTOMS: Have you had any of the following symptoms in the past month?
 Provide details below if necessary.

	Yes	No		Yes	No
Memory loss			Weight loss		
Trouble concentrating			Weight gain		
Loss of consciousness			Persistent fever		
Sedation/lethargy/sleepiness			Depression		
Abnormal vision			Anxiety		
Loss of Hearing			Hallucinations		
ringing in the ears			Insomnia		
Dizziness/vertigo			Chest pain		
Speech difficulties			Palpitations		
Swallowing difficulties			Shortness of breath		
Weakness in one part of the body			Persistent cough		
Clumsiness			Persistent nausea or vomiting		
Tremor/shaking			Persistent diarrhea		
Involuntary movements			Persistent constipation		
Rash			Abnormal bleeding/bruising		
Hair loss			Difficulty urinating		
Abnormal menstrual cycle			Incontinence		
Joint pains			Sexual difficulties		
Frequent headaches			Persistent pain (describe below)		

Comments/details:

Please list all of your **CURRENT MEDICATIONS**, including birth control pills, vitamins, aspirin, other over-the-counter medications, herbal remedies, etc:

Name of Medication	Tablet size (mgs)	Number of tablets you take and at what time of day
Example: Ambien	10 mg	One at bedtime

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

MEDICATION ALLERGIES (name of drug and type of reaction):

FAMILY HISTORY

A=alive or Current Age Major Illnesses/
D=deceased or age of death Cause of Death

Mother _____

Father _____

Brother/Sister _____

Brother/Sister _____

Brother/Sister _____

Brother/Sister _____

Brother/Sister _____

Child _____

Child _____

Child _____

List any **neurological** diseases (epilepsy, stroke, Parkinson's, multiple sclerosis, Alzheimer's, etc), including seizures, in your **family**:

SOCIAL HISTORY:

Are you currently working? Yes no. **Occupation:** _____

Marital Status: single married partnered widowed separated/divorced.

With whom do you live? _____

Number of children: _____

Education: less than high school grad high school grad college grad

Please provide a description of your sleep.

What time do you usually go to bed?

How long does it usually take you to fall asleep?

What time do you usually wake up in the morning?

Do you feel refreshed when you wake up?

Do you take naps? If so, how often and for how long?

Do you snore or have unusual movements during sleep?

Have you ever had hallucinations or paralysis when falling asleep or waking up?

Do you ever have uncomfortable sensations in your legs that keep you from falling asleep?

IF YOU HAVE SEIZURES: Please provide a description of each type.

Thank you very much for taking the time to fill out this form. This will help your physician(s) greatly.

Do you **currently** smoke? Yes no. How much? _____

If no, did you **ever** smoke? Yes no. When did you stop? _____

Do you **currently** drink any alcohol? Yes no. How much? _____

If no, did you **ever** drink? Yes no. When did you stop? _____

Do you **currently** use any recreational or illegal drugs? Yes no. Which ones?

If no, did you **ever** use recreational or illegal drugs? Yes no. Which one(s)?

Do you **exercise**? Yes no. If yes, what type and how much? _____

Are you presently **driving**? Yes no.

Do you have a driver's license? Yes no. If yes, which state? _____

If you are a woman:

Are you pregnant? Yes no not sure

When was your last menstrual period? _____

How would you describe your menstrual cycles? Regular Irregular Absent.

Please list any complications of prior pregnancies:

Epworth Sleepiness Scale

This scale is used to determine the level of daytime sleepiness. Please choose the most appropriate number for each situation over the past two weeks. Even if you don't usually do this activity, please give your best estimate:

- 0 = would never doze or sleep.
- 1 = slight chance of dozing or sleeping
- 2 = moderate chance of dozing or sleeping
- 3 = high chance of dozing or sleeping

Situation

Chance of Dozing or Sleeping

Sitting and reading

Watching TV

Sitting inactive in a public place

Being a passenger in a motor vehicle for an hour or more

Lying down in the afternoon

Sitting and talking to someone

Sitting quietly after lunch (no alcohol)

Stopped for a few minutes in traffic

Total score
