EPILEPSY INSTITUTE OF NORTH CAROLINA

Medical Patient History and Background Information

Name: _____ **Date:** ____ /____ / 20_____

Preferred name: _____ Person completing form: _____

Reason For Evaluation

What are your primary medical concerns at this time and/or specific questions you would like help with?

_____

_____

_____

Medical History

Check *Self or Relative* (blood relative) for a history of any of the following and, if so, explain. If a relative, list relation.

Alcoholism	☐ Self	☐ Relative	_____
Asthma	☐ Self	☐ Relative	_____
Depression	☐ Self	☐ Relative	_____
Diabetes	☐ Self	☐ Relative	_____
Heart disease	☐ Self	☐ Relative	_____
Lung disease	☐ Self	☐ Relative	_____
Stroke	☐ Self	☐ Relative	_____
Hypertension	☐ Self	☐ Relative	_____
Epilepsy	☐ Self	☐ Relative	_____
Trauma	☐ Self	☐ Relative	_____
Kidney disease	☐ Self	☐ Relative	_____
Liver disease	☐ Self	☐ Relative	_____
Thyroid disease	☐ Self	☐ Relative	_____
Mental illness	☐ Self	☐ Relative	_____
Cancer	☐ Self	☐ Relative	_____
Headaches/Migraines	☐ Self	☐ Relative	_____
Headaches/Tension	☐ Self	☐ Relative	_____
Bleeding disorder	☐ Self	☐ Relative	_____
Allergy/Hay fever	☐ Self	☐ Relative	_____
Sleep disorder	☐ Self	☐ Relative	_____

Present Medical Issues

Present medical conditions: _____

_____

Allergies (medication, etc.): _____

_____

Surgical procedures (procedure and year): _____

_____

_____

Hospitalizations (other than surgical procedures, include year): _____

_____

_____

Currently prescribed medication(s)? ☐ No ☐ Yes

Medication	Dosage	Duration	Reason for use/Comments

Currently use vitamins (V), supplements (S), and/or over the counter (OTC) medications?

Name	Type	Dosage	Reason for use/Comments
Ex. Fish oil	*S*	*1200 mg*	*Cholesterol/hypertension*

Medications used in the past and/or adverse effects of medications used in the past.

Name	Prior use	Adverse effect	Reason for stopping

Compliance Assessment

How often do you miss a dose of medication? ☐ Never ☐ Rarely ☐ 1 - 2 per week ☐ 3 - 4 per week ☐ Often

Are you having any problems with your medication regimen? ☐ No ☐ Yes _____

_____

_____

Are medication costs a concern for you? ☐ No ☐ Yes _____

_____

_____

Social Information

Please check: ☐ *Married* ☐ *Separated* ☐ *Divorced* ☐ *Widowed* Number of children ___ Veteran: ☐ No ☐ Yes

Place of birth _____ Siblings ☐ No ☐ Yes How many? _____

Education (highest level completed): ☐ Grade school ☐ High school ☐ College ☐ Professional school

Employer _____ Occupation _____

Type of work: ☐ Sedate ☐ Mildly active ☐ Moderately active ☐ Vigorously active

Alcohol Usage: ☐ Currently Every Day ☐ Currently Some Days Amount:_____ Type: _____
☐ Former - Age Quit _____ ☐ Never

Tobacco Usage: ☐ Currently Every Day ☐ Currently Some Days Amount:_____ Type: _____
☐ Former - Age Quit _____ ☐ Never

Caffeine Usage: ☐ Currently Every Day ☐ Currently Some Days Amount:_____ Type: _____
☐ Never

Recreational Drug Usage: ☐ Currently Every Day ☐ Currently Some Days Type: _____
☐ Former - Type: _____ ☐ Never

Please check *No* or *Yes* for any of the following in the last year, and if yes, please explain:

Family relocate ☐ No ☐ Yes _____

Marital problems ☐ No ☐ Yes _____

Serious spouse illness ☐ No ☐ Yes _____

Serious child illness ☐ No ☐ Yes _____

Serious accident to family member ☐ No ☐ Yes _____

Job difficulties/loss ☐ No ☐ Yes _____

Death of close family member ☐ No ☐ Yes _____

If there is other information that you think will be helpful to us, please explain below:

_____

_____

_____

_____

_____

_____