

Today's Date: _____

Deepak Madhavan, MD

Patient Intake Sheet

Full Name: _____ Date of Birth: _____ Gender: ___M ___F

Please answer each question. This information is confidential and is needed to provide a better idea of your overall health. Please bring the completed form with you to your appointment.

1. How old were you when you first had a seizure? _____
2. How often do you have seizures currently?
 Daily Weekly Monthly Other: _____
3. Do you have an immediate family member(s) who has seizures ___Yes ___ No ___ Not sure
 If yes, do you know what type of seizure that they have? Describe.
4. Have you ever had:

4a. A head injury with loss of consciousness?	___Yes ___No
4b. A brain infection (meningitis, encephalitis)?	___Yes ___No
4c. Brain Surgery?	___Yes ___No
4d. Febrile (fever seizure)?	___Yes ___No
5. What (if any) epilepsy seizure medicines are you currently taking?
6. What epilepsy medicines have you taken in the past? Check all that apply.

<input type="checkbox"/> Phenytoin (Dilantin, Phenytek) <input type="checkbox"/> Topiramate (Topamax) <input type="checkbox"/> Valproate (Depakote, Depakene) <input type="checkbox"/> Carbamazepine (Tegretol, Depakene) <input type="checkbox"/> Oxcarbazepine (Trileptal) <input type="checkbox"/> Leviteracetam (Keppra) <input type="checkbox"/> Valium (Diazepam, Diastat) <input type="checkbox"/> Acetazolamide (Diamox) <input type="checkbox"/> Pregabalin (Lyrica) <input type="checkbox"/> Lamotrigine (Lamictal)	<input type="checkbox"/> Zonisamide (Zonegran) <input type="checkbox"/> Lorazepam (Ativan) <input type="checkbox"/> Clonazepam (Klonopin) <input type="checkbox"/> Gabapentin (Neurontin) <input type="checkbox"/> Tiagabine (Gabatril) <input type="checkbox"/> Ethsuximide (Zarontin) <input type="checkbox"/> Felbamate (Felbatol) <input type="checkbox"/> Clobazam (Frisium) <input type="checkbox"/> Clobazam (Frisium) <input type="checkbox"/> Other _____
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7. Describe any other medical conditions that you have?

Are you currently under care of a medical provider? ___Yes ___No
8. Are you taking any other prescribed medication and/or herbal remedies? Describe.
9. Do you drink alcoholic beverages? ___Yes ___No
10. Do you take any illicit drugs? ___Yes ___No If Yes, what kind and how often?

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11. Have you recently experienced (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Sweats | <input type="checkbox"/> Muscle Pain |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Vision Difficulties | <input type="checkbox"/> Severe Fatigue |
| <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Persistent Infections | <input type="checkbox"/> Frequent Urination/Urgency |
| <input type="checkbox"/> Persistent Headaches | <input type="checkbox"/> Other _____ |

12. Have you been diagnosed with depression? Yes No

13. Do you think you may be experiencing symptoms of depression? Yes No

14. Have you ever received an electroencephalogram (EEG) Yes No

15. Have you ever received a brain MRI? Yes No.

Please feel free to discuss any points with the care provider upon the time of the visit.

Thank you for completing this important form.

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