COMPREHENSIVE EPILEPSY/ SLEEP CENTER
PATIENT INFORMATION SHEET FOR FOLLOW-UP VISIT

Name:_____Date:_____

Address: _____City: _____State: _____Zip: _____

Phone Number: _____

Accompanied to appointment by (circle) Spouse/Partner Child Parent Sibling Friend Other

Please list your current medication:
_Name of medication_____ _#mgs per tablet___ ____ #of pills you take & at what time_____
Example____Tegretol XR_____20mgs_____2@8am and3@8pm_____
_____
_____
_____
_____
_____
Have you had surgery or been hospitalized since your last visit? YES NO (If yes please describe on back of page)

*****Which doctor should receive a report of this visit?** (Please complete Entirely)

Name: _____

Address_____City: _____ *State:*____Zip Code:_____ Phone Number: _____

Do you currently smoke? Yes No If so, how much? _____
Do you currently drink? Yes No If so, how much? _____
Does anyone in your family have seizures or other neurological conditions? Yes No (If Yes please describe on back of page?
Who do you currently live with? _____
Employer: _____
Type of medical Insurance: _____

Are you currently experiencing any of the following symptoms? (Check the appropriate column for each)

SYMPTOM	YES	NO	SYMPTOM	YES	NO	SYMPTOM	YES	NO
Lethargy/sleepiness			Poor memory			Depression		
Headaches			Abnormal vision			Change in weight		
Tremors			Abnormal Speech			Hair Loss		
Dizziness			Poor concentration			Other		

Have you ever had any of the following medical conditions? (Check the appropriate column for each)

Condition	YES	NO	Condition	YES	NO	Condition	YES	NO
Heart condition/arrhythmia			Depression/psychiatric disorder			Urology disorder		
Diabetes			Ulcers/Gastrointestinal disorder			Blood disorder		
High blood pressure			Immune disorder			Cancer		
Thyroid condition/other endocrine disorder			Glaucoma			Insomnia		
Emphysema/asthma or other lung disorder			Psoriasis/skin disorder			Other		

How many seizures have you had since your last visit? _____
Are there special concerns you would like to discuss today? _____
_____
_____

PHYSICIAN SIGNATURE: _____DATE: _____