# 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.**

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**2.**

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**3.**

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**4.**

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**5.**

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**6.**

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**7.**

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**8.**

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**9.**

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**10.**

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

**FAMILY HISTORY** A=alive or D=deceased | Current Age or age of death | Major Illnesses/ 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

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** | ____ |

**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.***

# The Neurological Disorders Depression Inventory for Epilepsy (NDDIE)

Date: _____

Name: _____

**For the statements in this table, please select the number that best describes them over the last 2 weeks, including today.**

| | ***Always or often*** ***4*** | ***Sometimes*** ***3*** | ***Rarely*** ***2*** | ***Never*** ***1*** |
|---|---|---|---|---|
| Everything is a struggle | ☐ | ☐ | ☐ | ☐ |
| Nothing I do is right | ☐ | ☐ | ☐ | ☐ |
| Feel guilty | ☐ | ☐ | ☐ | ☐ |
| I'd be better off dead | ☐ | ☐ | ☐ | ☐ |
| Frustrated | ☐ | ☐ | ☐ | ☐ |
| Difficulty finding pleasure | ☐ | ☐ | ☐ | ☐ |