# Health History Questionnaire

## 1. Medical History
- **Anemia**
- **Anxiety**
- **Arthritis**
- **Asthma**
- **Bleeding Disorder**
- **Blood Clots/DVT**
- **Cancer**
- **CHF/Heart Failure**
- **Depression**
- **Diabetes**
- **Emphysema/COPD**
- **GERD/Heartburn/Acid Reflux**
- **Heart Disease**
- **HIV/AIDS**
- **Hypertension/High Blood Pressure**
- **Kidney Disease**
- **Liver Disease**
- **Palpitations/Racing Heart**
- **Seizures**
- **Stroke**
- **Thyroid Problems**

Other _________________

## 2. Surgical History
- **No surgery**
- **Anesthesia Complications**
- **Appendectomy**
- **Breast surgery**
- **Colonoscopy**
- **Coronary Artery Bypass**
- **Coronary Artery Stent**
- **Eye Surgery**
- **Gallbladder Surgery (Cholecystectomy)**
- **Hernia repair Location _______________**
- **Hysterectomy**
- **Joint Replacement**
- **Prostate Surgery**
- **Spine Surgery**
- **Organ Transplant**
- **Other________________**

## 3. Social History
- **Alcohol Use**
  - Yes
  - No
  - Never
- **Wine**
- **Beer**
- **Liquor**
- **Drinks per Week ____________**
- **Street Drug Use**
  - Yes
  - No
  - Never
- **Marijuana**
- **Methamphetamines**
- **Cocaine**
- **Heroin**
- **Other**
- **Tobacco Use**
  - Yes
  - No
  - Never
  - Type _________________
  - Current Smoker Packs per day _____
  - Former Smoker Packs per day _____
- **Sexually Active**
  - Yes
  - No
  - Not Currently Partners
  - Check all that apply
  - Female
  - Male

**Birth Control / Protection**
- Yes
- No
- Method _________________

## 4. Family Medical History  Check all that apply.

- I have no family history
- I have unknown family history

## Relationship

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If you have completed sections 1-4 since your last birthday, please proceed to section 5.

**5. Strong Epilepsy Center**

With which hand do you write? □ Left □ Right □ Ambidextrous

**Seizures:**

At what age did you have your first seizure? _______________

Describe your first seizure __________________________________________________________________________

Was there any known reason for your first seizure? □ Yes □ No Describe _________________________________

At what age did you have your next seizure? __________________________________________________________

How many different types of seizures do you have? ____________________________________________________

Describe your current seizure(s) _____________________________________________________________________

Do you have a warning before your seizures? □ Yes □ No Describe ______________________________________

How long does it take for you to return to normal after a seizure? ________________________________________

When was your most recent seizure? ________________________________________________________________

How often do your current seizures occur? __________________________________________________________________________

How do the seizures affect your everyday life? __________________________________________________________________________

When was the last time you were in emergency or admitted to a hospital for your seizures? ___________

Why? ___________________________________________________________________________________________

Are your seizures related to your menstrual cycle? □ Yes □ No □ Not Applicable

Did you have a childhood febrile convulsion (seizure with fever age 5 or younger)? □ Yes □ No □ Unknown

Did you ever have a head injury with loss of consciousness: □ Yes □ No Describe __________________________

Did you ever have a brain infection (meningitis or encephalitis) □ Yes □ No Describe ______________________

Do you have any birthmarks? □ Yes □ No Describe ____________________________________________________

Were you ever treated for depression, anxiety or other mental health problems: □ Yes □ No

Were you ever the victim of abuse: □ Emotional □ Physical □ Sexual □ None

List your current mental health providers

Counselor ______________________________________ Psychiatrist ________________________________ □ None

Were you ever told you have Epilepsy? □ Yes □ No Type ______________________________________________
5. Strong Epilepsy Center

Anti-Seizure Medications:

Check all that you take presently or have taken in the past.

If you took the medication in the past, check the box and explain why you stopped.

- □ acetazolamide (Diamox)
- □ cannabidiol (Epidiolex)
- □ carbamazepine (Tegretol, Carbatrol)
- □ chlorazepate (Tranxene)
- □ clobazam (Onfi, Frisium)
- □ clonazepam (Klonopin)
- □ diazepam (Valium)
- □ eslicarbazepine (Aptiom)
- □ ethosuximide (Zarontin)
- □ ezogabine (Potiga)
- □ felbamate (Felbatol)
- □ gabapentin (Neurontin)
- □ lacosamide (Vimpat)
- □ lamotrigine (Lamictal)
- □ levetiracetam (Keppra)
- □ lorazepam (Ativan)
- □ oxcarbazepine (Trileptal)
- □ phenobarbital
- □ phenytoin (Dilantin/Phenytek)
- □ perampanel (Fycompa)
- □ pregabalin (Lyrica)
- □ primidone (Mysoline)
- □ rufinamide (Banzel)
- □ stiripentol (Diacomit)
- □ tiagabine (Gabitril)
- □ topiramate (Topamax)
- □ valproic acid (Depakote, Depakene)
- □ vigabatrin (Sabril)
- □ zonisamide (Zonegran)
- □ other

What was your first anti-seizure medication and when was it started? ________________________________________________

Which anti-seizure medicine(s) did you like best and why? _________________________________________________________

Which anti-seizure medicine(s) was your least favorite and why? ____________________________________________________

Do you have any side effects from your current medications? □ Yes □ No Describe

When was the last time you missed any of the anti-seizure medicines? _______________________________________________

Do you have a Vagal Nerve Stimulator (VNS)? □ Yes □ No

Do you have a NeuroPace Responsive NeuroStimulator (RNS)? □ Yes □ No