



Mid-Atlantic  
EPILEPSY & SLEEP CENTER

**Initial Visit Questionnaire**

Date: \_\_\_\_\_ Referring/Primary Doctor: \_\_\_\_\_

Name: \_\_\_\_\_ Doctor's Office Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_  Male  Female

What is the reason for your visit today?

\_\_\_\_\_

Location and severity of the problem

\_\_\_\_\_

How long have you had these symptoms?

\_\_\_\_\_

When do the symptoms occur?

\_\_\_\_\_

What makes the symptoms worse?

\_\_\_\_\_

What makes the symptoms better? (Include medications)

\_\_\_\_\_

Are you: (check one): \_\_\_ Left Handed \_\_\_ Right Handed \_\_\_ Ambidextrous

Are the symptoms related to an injury? **YES NO** Was the injury work related? **YES NO**

Date of Injury: \_\_\_\_\_

Are you presently working? **YES NO** Date last worked: \_\_\_\_\_ Work Capacity: **Full time Part time**

Job Title or Duties:

\_\_\_\_\_





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**Family History:** List any medical problems in your immediate family

Father: \_\_\_\_\_ Age (Alive/ Deceased) \_\_\_\_\_

Mother: \_\_\_\_\_ Age (Alive/Deceased) \_\_\_\_\_

Sibling: \_\_\_\_\_ Age (Alive/Deceased) \_\_\_\_\_

**Social History:** (Circle the correct Answer)

Marital Status:    Single                      Married                      Significant Other                      Divorced                      Widow(er)

Education:            Grade School            Middle School            High School                      College                      Graduate School

Do you exercise? \_\_\_\_\_ How often per week? \_\_\_\_\_ Are you on any special diet? \_\_\_\_\_

Do you currently smoke? \_\_\_\_\_ If so, amount per day? \_\_\_\_\_ How many years? \_\_\_\_\_

Do you drink alcoholic beverages? \_\_\_\_\_ How many glasses per day? \_\_\_\_\_ How many years? \_\_\_\_\_

Do you use recreational drugs? \_\_\_\_\_ Drug of choice? \_\_\_\_\_

**Known Drug Allergies**

**Known Drug Intolerance**

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**Current medications (list below) include herbal remedies and vitamins:**

Name of medications	Number of milligrams	Number of tablets taken in one day

My signature signifies that I have read, understand, and truthfully answered this medical form.

\_\_\_\_\_

\_\_\_\_\_

Signature of Patient

Date