EEG

PATIENT HISTORY QUESTIONAIRE

(Must be completed by patient)

Mid-Michigan Sleep Center
8203 S. Saginaw St. Grand Blanc, MI 48439
Phone: 810-953-3600 Fax: 810-953-9547

Background information:

Name: _____Age:_____ Birthdate:_____ Sex: M / F

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Email:_____Occupation:_____

Approximate height:_____ Weight:_____ Shift work:_____

Family Doctor:_____ Referring Doctor:_____

Please briefly describe why you were referred or what problems you are having?

How long have you had this problem?_____ Is your problem worsening? Yes / No_____

Medications/Inhalers May make separate list	**Dose**	**Frequency**
Drug Allergies		**Reaction**
Other Allergies		**Reaction**
Surgical History		**Date**

General Review of Systems
Check all the apply

- ○ Weakness
- ○ Headache
- ○ Migraines
- ○ Short of breath
- ○ Heart Palpitations
- ○ Heat/cold intolerance
- ○ Swelling
- ○ Depression
- ○ Dizziness
- ○ Sweating
- ○ Anxiety
- ○ Blurred vision
- ○ Chest pain
- ○ Bruising easily
- ○ Numbness/tingling
- ○ Memory problems
- ○ Ringing in ears
- ○ Neck stiffness
- ○ Jaundice
- ○ Muscle/joint pain
- ○ Tremors
- ○ Hyperactivity
- ○ Seizures
- ○ Alzheimers/Dementia
- ○ Aneurysm
- ○ Hepatitis
- ○ Other Medical Conditions:
- ○ _____
- ○ _____
- ○ _____
- ○ _____

- ○ Pacemaker
- ○ Stroke
- ○ Passing out
- ○ Low blood pressure
- ○ High blood pressure
- ○ Heart attack
- ○ Chronic Kidney Disease
- ○ COPD
- ○ Schizophrenia
- ○ Transient Ischemic Attack (TIA)
- ○ Diabetes
- ○ Vertigo
- ○ Unsteady walking
- ○ Imbalance while standing
- ○ Head injury
- ○ Obstructive sleep apnea
- ○ Parkinson's disease
- ○ Tumor Type:_____
- ○ Epilepsy
- ○ Strokes
- ○ Swallowing problems
- ○ Speech problems

EEG HISTORY QUESTIONAIRE CONTINUED…

Have you had an EEG before?

If yes, when and for what disorder/symptom?

Where and when?

Social History:

Do you smoke?_____ Did you previously smoke?_____

Number of years smoking_____ How much per day_____

Do you drink alcohol?_____

How much _____ drinks (daily/weekly/monthly)

How many caffeinated beverages do you drink daily?

Caffeine (Coffee, Tea, Chocolate, Energy drinks) in AM_____

Caffeine after noon_____ Caffeine all day_____

Recreational Drugs?_____

Do you exercise regularly? _____

What time of day do you exercise?_____

Are you left or right handed?_____

Describe your typical attack or symptoms:

_____

_____

Do you have any other medical disorders or problems not listed on this questionnaire? If so, please list them below.

_____

_____