McLaren

THUMB REGION

Cardiopulmonary Department
EEG Patient History & Information

Date _____ EEG# _____ In-pt. Or Out-pt.:_____

Rt. Or Lt. Handed _____ Last Meal _____ Previous EEG's: _____

Sleep Deprived_____ Activation – HV _____ PS _____

Patient Name: _____ Age: _____ D.O.B. _____

Medications: _____

Ordering Dr./Family Dr.: _____ Diagnosis: _____

Patient Condition; Awake Drowsy Asleep Alert Confused Lethargic Comatose
Patient Cooperation; Good Fair Poor Anxious Restless Hyperactive

Seizures: Date of Onset_____ Last seizure _____ Family History_____
Description _____

Headaches: Date of Onset _____ Location _____
Nature: Throbbing Dull Ache Sharp Pain Dizziness Nausea Vomiting
Visual Disturbance

Stroke: Date _____ Prior History _____
Clinical Signs: Weakness Slurred Speech Facial Droop Headaches
How long did clinical signs last? _____ Were they focal? _____

Children: Illnesses _____ Seizures with fever _____
Trauma _____ Physical & Mental Development _____
Birth: Normal Abnormal Full Term Premature
Pregnancy: Normal Abnormal

Trauma: Date _____ Loss of Consciousness _____ How long? _____
Description _____

Post Trauma: Dizziness Amnesia Weakness Paralysis

History: Hospitalizations or Serious Illnesses _____

History of Drug or Alcohol Abuse _____
Additional Comments _____