HEALTH
UNIVERSITY OF MINNESOTA
MINCEP® EPILEPSY CARE

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Clinic (952) 525-4500
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Patient Name _____

Date _____

Supplemental Pediatric Information

The following questions relate to your child's development. Be as complete as you can be. If you need additional space, please attach additional page(s) and write in the number of the question you are answering.

77. Did the patient have any problems in the newborn period? ◯ Yes ◯ No a. If YES, Describe:

_____

_____

78. Developmental Milestones:

(Please mark those things the patient can do, and the age at which she/he learned it. Respond in months, or years and months. If you cannot remember the exact age, list the approximate age. Example: Age: 2 months OR 3 years 4 months).

a. Motor Development and Coordination:

		If yes, Age:			If yes, Age:
Rolls over	◯ Yes ◯ No	_____	Walks alone	◯ Yes ◯ No	_____
Crawls	◯ Yes ◯ No	_____	Climbs stairs	◯ Yes ◯ No	_____
Sits without support	◯ Yes ◯ No	_____	Runs	◯ Yes ◯ No	_____
Stands alone	◯ Yes ◯ No	_____	Rides a bike	◯ Yes ◯ No	_____

b. Fine Motor and Self-Care Skills:

		If yes, Age:
Grasps objects within reach	◯ Yes ◯ No	_____
Transfers objects from hand to hand	◯ Yes ◯ No	_____
Picks up small objects (Cheerios)	◯ Yes ◯ No	_____
Uses spoon or fork to feed self	◯ Yes ◯ No	_____
Can dress self, except tying shoes	◯ Yes ◯ No	_____
Uses pencil/crayon to draw recognizable pictures	◯ Yes ◯ No	_____
Prints letters	◯ Yes ◯ No	_____
Can print or write name	◯ Yes ◯ No	_____
Is toilet trained	◯ Yes ◯ No	_____
Can care for self with minimal supervision	◯ Yes ◯ No	_____
Ties shoes	◯ Yes ◯ No	_____

c. Language Skills:

		If yes, Age:
Coos or gurgles	◯ Yes ◯ No	_____
Imitates sounds (babbling that sounds like real words	◯ Yes ◯ No	_____
Says single words	◯ Yes ◯ No	_____
Says sentences	◯ Yes ◯ No	_____
Understands and can comply with simple commands ("Sit down")	◯ Yes ◯ No	_____
Follows directions of 2-3 parts ("Go to your room", "Pick up your toys")	◯ Yes ◯ No	_____
Counts	◯ Yes ◯ No	_____
Reads	◯ Yes ◯ No	_____
Does simple math	◯ Yes ◯ No	_____
Tells time	◯ Yes ◯ No	_____

79. How long will the patient stay with an activity she/he enjoys?(approx. # of minutes) _____

80. Do you think the patient's development is normal? ○ Yes ○ No

_____

_____

81. Behavior: (Please mark any term that you think describes the patient at least half of the time.)

☐ Active child	☐ Cries easily	☐ Has a strong temper	☐ Irritable	☐ Poor self-esteem	☐ Talkative
☐ Aggressive	☐ Depressed	☐ Helpful	☐ Moody	☐ Selfish	☐ Wide mood swings
☐ Attentive	☐ Easygoing	☐ Hyperactive	☐ No confidence	☐ Short attention span	☐ Withdrawn
☐ Cooperative	☐ Friendly	☐ Impulsive	☐ Over dependent	☐ Shy	

82. Do you have concern's about the patient's behavior? ○ Yes ○ No

_____

_____

83. Do you consider the patient's school work to be satisfactory? ○ Yes ○ No

84. Has the patient missed more than 5 days of school in the past year? ○ Yes ○ No

85. Has the patient missed more than 5 days of school due to her/his seizures in the past year? ○ Yes ○ No

86. Who are the patient's family members?

Name:	Age:	Relation: