EPILEPSY/SEIZURE HISTORY FORM

Please fill out this questionnaire as best you can; your answers provide valuable information but remember, there are no “right” or “wrong” answers!

If you have more than one type of seizure, answer these questions for your most frequent seizure type. You may describe your other seizure types at the end of the questionnaire, using sections 2-4 as a guide.

If anyone has witnessed your seizures, please ask them to assist you in answering sections 2-4. If possible, please bring a knowledgeable witness to your clinic visit.

1. Onset of seizure:
My seizures started at age _______ or _______ months ago (if less than one year ago).

Changes in seizures:
- ____ no significant change
- ____ my seizures became ___ more frequent ___ less frequent ___ more intense ___ less intense
  when? ___ years ago ___ months ago

2. Before the seizure:
Do you have any of the following symptoms prior to your seizure?
- ____ None.
- ____ nausea ____ "funny" feeling in my stomach ____ visual changes ____ odd smell ____ fear/anxiety
  Other: _____________________ How long before the seizure starts?__________________________

3. During the seizure:
- ____ No.  ____ Yes
- Can you understand others speaking to you?  ____ No.  ____ Yes
- Can you speak to others?  ____ No.  ____ Yes
- Have you ever bitten your tongue?  ____ No.  ____ Yes
- Have you ever lost control of your bowel or bladder?  ____ No.  ____ Yes
- Have you ever seriously injured yourself?  ____ No.  ____ Yes

Briefly describe the typical sequence of events during your seizures, including any abnormal movements:________________________________________________________________________
  ____________________________________________________________________________

How long do your seizures typically last? ________ If you are fully alert after your seizures, skip section 4.

4. After the seizure:
If you are not fully alert after the seizure, how do you typically feel (check all that apply):  ____ tired/sleepy  ____ disorientated  ____ aching (head/muscles)  ____ combative  ____ depressed
  Other__________________________________________ How long until you are completely "back to normal"?__________

5. Frequency:
- My seizure occurs ____ times per day - week - month - year (circle one)
- Do your seizures usually occur at same time of day or night? If so, when?_________________________

6. Family history:
- Does/did any blood relative of yours have seizures?  ____ No  ____ Yes. If so, list whom and please give any known details:______________________________
7. **Other history:**
   a. Did you ever have febrile seizures as an infant? ____________________________
   b. Did you ever have meningitis or encephalitis (infections of the brain)? ____________________________
   c. Did you ever have a head injury which caused you to lose consciousness? If so, please provide the year(s) and a brief description: _______________________________________
   d. Have you ever been diagnosed with cancer?_____ If so, please provide the year and a brief description: _______________________________________
   e. Have you been experiencing any of the following? _____ depressed mood _____ lack of sleep or excessive fatigue _____ excessive physical or emotional stress

8. **Prior evaluation:** Were any of these tests performed specifically to evaluate your seizures? If so, please give approximate date(s) of when the test(s) were performed.
   CT scan of the brain _______ MRI scan of the brain___________ EEG (electroencephalogram)_____

9. **Prior treatments:** List any prescription medications and dosages you have tried in the past for seizures and their effects: (please list your current medications for seizures on the “Clinical Summary” questionnaire):

<table>
<thead>
<tr>
<th>Drug name</th>
<th>approx. dates used</th>
<th>highest dosage</th>
<th>times per day</th>
<th>effect on seizures</th>
<th>Side effects (if any)</th>
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10. Describe any other seizure types you may have, using sections 2-4 as a guide:

Thank you again. Please also fill out the “Neurology Clinical Summary” questionnaire.