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EPILEPSY/SEIZURE HISTORY FORM

PATIENT NAME: ________________________________ **DATE:** _____________

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: *Do you lose consiousness?* ____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 you 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):

Drug name	approx. dates used	highest dosage	times per day	effect on seizures	Side effects (if any)

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.