SEIZURE HISTORY

Patient's Name: _____ Date _____

Are you a product of a normal pregnancy and delivery? □YES □NO
If no, please explain: _____
_____

Did you have normal development in cognitive and motor skills in early childhood?
□YES □NO
If no, please explain: _____
_____

Was there any trauma/injury or illness reported before the onset of seizures?
□YES □NO
If yes, when did the accident/trauma/illness occur: _____
When did the seizures start after the accident: immediately, gradually.
Please describe the event. _____
_____

ONSET/TIMING age/date of onset _____ average frequency _____ Current

frequency _____

How many times has the seizure(s) occurred?
□Less than 10 times:_____ times up to now.
□10-20 times,
□20-30 times,
□more than 30 times.

How long does the seizure last? (Include the time of unconsciousness not the recovery times).
□ _____ seconds.
□ _____ minutes.
□ _____ hours.

PRECIPITATING FACTORS: history of stroke _____ head trauma _____

meningitis _____ encephalitis _____

TRIGGERS: Stress _____ flashing lights _____ menstrual cycle _____ lack of sleep _____

_____ alcohol withdrawal _____ medication withdrawal _____

Do you experience any symptoms before you have a seizure? □YES □NO
If yes, please check all symptoms that apply to your seizure:

□lightheadedness, □a warm of flushed sensation, □nausea, , □fear, □déjà vu, □numbness, □visual hallucination, □auditory hallucination, □ear ringing, □smell an odor, □involuntary twitching in extremities, □tingling/numbness of the extremities, □disturbances of body image, □vertigo, □unable to speak, □crying out, □laughter,
□Other: _____.

How long do the above symptoms last before the seizure starts? _____.

During the time of the seizures:
What do witnesses describe? Please check all that apply:

□ facial paleness/excessive sweat, □flaccid body and limbs, □brief body and limb shaking (within 15 seconds), □prolonged body and limb shaking (more than 15 seconds), □blue color in the face, □rhythmic jerking movements, □body stiffness, □eyes, □tight jaw biting, □tongue biting, □bowel/ bladder incontinence
□Other: _____.

After recovery of consciousness:
Immediately after the recovery of consciousness, what happens to you? Please circle all that apply:

□good recall of what happened before the seizure, □ brief confusion (less than several minutes), □ prolonged confusion (more than several minutes), □no recollection of what happened before the seizure (amnesia), □muscle soreness, □weakness on one side of body, □numbness on one side of body. □Other: _____.

When do most of your seizures occur? Please circle: □during the day, □right after awakening from sleep, □falling asleep, □during sleep.

Do you have a family history of seizure disorders? □YES □NO

Have you ever been evaluated by a neurologist for seizures? □YES □NO
If yes, which doctor? _____

Have you ever had any brain imaging done after the onset of seizures? □YES □NO
If yes, which: CT scan of the brain/ head, MRI of the brain/ head.

Have you ever had an EEG (brain wave study) before? □YES □NO
If yes, what did it show? □Normal, □Abnormal seizure like activity,
□Other: _____.

When was your last EEG? _____.

Have you had seizures within the last 10 years? □YES □NO

When was your last seizure? _____

Description of Seizure Events:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____.

THIS SECTION IS FOR SEIZURE TREATMENT:

Are you currently on seizure medication? □YES □NO
If yes, please list medication(s) and dosage:

_____
_____

Has there been any medication discontinued due to side effects?
If yes please circle all that apply:

Dilantin, □Depakote, □Tegretol, □Carbatrol, □Trileptal, □Lamictal, □Topamax, □ Zonegran, Neurontin, □Keppra, □Topamax, Phenobarbital, □Primidone, □Ethosuximide, □Other: _____.

What was the side effect? _____
_____
_____