

ASSOCIATED NEUROLOGICAL SPECIALTIES

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Patient Name: _____ Today's Date: _____

CHIEF COMPLAINT-EPILEPSY

1. When was your last seizure?

2. Describe your last seizure.

3. How long was the seizure?

4. Were the eyes opened or closed?

5. Did one side seem more involved than the other?

6. Did you bite your tongue?

7. Did you lose your urine?

8. Can you tell the seizure is coming?

9. Do you have an aura or warning? _____ If so, describe.

10. What is the longest seizure you have ever had?

11. What happens after the seizure?

CHIEF COMPLAINT-EPILEPSY CONTINUED:

12. When was your first seizure in your life?
13. Do you know how many seizures you have had in your life?
14. Is there a family history of epilepsy or seizure?
15. Do you have a history of serious head trauma?
16. Did you have seizures as a child with fever?
17. Have you ever been on medication for seizures? _____ If so, what medication? List medications and response to treatment.
 - a. Dilantin
 - b. Tegretol
 - c. Depakote
 - d. Phenobarbital
 - e. Other
18. Are you allergic to any anticonvulsant medication?
19. Have you had any adverse responses to anticonvulsant medication?
20. Is there a trigger for these seizures that you have identified?
21. What do you think is the cause of these seizures?
22. Do you know that you cannot drive for six months following a seizure?
23. What specific questions do you have about seizures and epilepsy?

