

SEIZURES QUESTIONNAIRE

To be completed by the treating physician
(PLEASE USE BLOCK LETTERS)



1. PATIENT'S INFORMATION

Name	Last	First	M.I.
Date of birth	MM / DD / YYYY	Height ☐ M ☐ Ft	Weight ☐ Kg ☐ Lb

2. MEDICAL INFORMATION

Date of first symptom	Symptoms
MM / DD / YYYY	
Date of last consultation	Diagnosis
MM / DD / YYYY	

Type of seizure			Etiology
I. Partial (focal)	☐ Simple	☐ Complex	☐ Primary (idiopathic) ☐ Secondary
II. Generalized	☐ Absence seizures ☐ Myoclonic ☐ Tonic - Clonic	☐ Clonic ☐ Tonic	
Associated with:			
☐ Yes ☐ No	Hyperpyrexia		
☐ Yes ☐ No	CNS infections (meningitis, encephalitis)		
☐ Yes ☐ No	Metabolic disturbances (hypoglycemia, etc.)		
☐ Yes ☐ No	Convulsive or toxic agents (chloroquine, alcohol)		
☐ Yes ☐ No	Cerebral hypoxia (Adams Stokes Syndrome, anesthesia, etc.)		
☐ Yes ☐ No	Expanding brain lesions (neoplasm, intracranial hemorrhage, etc.)		
☐ Yes ☐ No	Brain defects		
☐ Yes ☐ No	Cerebral edema		
☐ Yes ☐ No	Anaphylaxis		
☐ Yes ☐ No	Cerebral infarction or hemorrhage		
☐ Yes ☐ No	Cerebral trauma		
Date of last attack	MM / DD / YYYY	Number of attacks in the last 12 months	

Diagnostic method	Details	
☐ CT scan	Result	
	Treatment	
Date	Prognosis	
MM / DD / YYYY	Current condition	

Diagnostic method	Details		
☐ MRI	Result		
	Treatment		
Date	Prognosis		
MM / DD / YYYY	Current condition		
Diagnostic method	Details		
☐ EEG	Result		
	Treatment		
Date	Prognosis		
MM / DD / YYYY	Current condition		
Diagnostic method	Details		
☐ Arteriography	Result		
	Treatment		
Date	Prognosis		
MM / DD / YYYY	Current condition		
Diagnostic method	Details		
☐ Tumor excluded	Result		
	Treatment		
Date	Prognosis		
MM / DD / YYYY	Current condition		
Diagnostic method	Details		
☐ Other	Result		
	Treatment		
Date	Prognosis		
MM / DD / YYYY	Current condition		

3. TREATING PHYSICIAN'S INFORMATION

Name			
Address			
Telephone		Fax	
Email			
Signature		Date	MM / DD / YYYY