Seizure Questionnaire

NAME: _____ DOB: _____ DATE_____

If more than one symptom is listed on a line, circle the relevant problem.

- History of seizure with a high fever as a child (febrile seizures)? No ◯ Yes ◯
- Last major seizure: _____ days / weeks / months / years ago.
- Frequency of major seizure: _____ How many per week / month / year
- Last minor seizure: _____ days / weeks / months / years ago.
- Frequency of minor seizure: _____ How many per week / month / year
- Episodes of de-realization, out of body experience? No◯ Yes◯
- Falling out of bed? No◯ Yes◯
- Face or arm twitching in the morning? No ◯ Yes◯
- Staring spells? No◯ Yes ◯
- Family history of seizures? If yes, who? _____
- Seizures are provoked by:

  Flashing lights Not sleeping Not eating Stress Fever Allergies Pain

- Seizures start with an aura of:

Rising sensation	Slurred speech	Shortness of breath	Bad smell
Confusion	Palptiation	Fear	Tremors
Sweating	Flashing lights	Dizziness	Scream
Tunnel vision			

  Numbness or tingling: No◯ Yes ◯ If yes, where? _____

  Pain: No ◯ Yes ◯ If yes, where? _____

  Twitching: No ◯Yes◯ If yes, where? _____

- Current Seizure Medications:

Dilantin	Zonegran	Ativan	Aptiom	Phenobarbital	Trileptal
Clobazam	Fycompa	Tegratol	Lamictal	Diamox	Mysoline
Keppra	ACTH	Depakote	Topamax	Detogenic Diet	Zarontin
Felbatol	Vimpat	OTHER: _____			

- Prior seizure medication

Dilantin	Zonegran	Ativan	Aptiom	Phenobarbital	Trileptal
Clobazam	Fycompa	Tegratol	Lamictal	Diamox	Mysoline
Keppra	ACTH	Depakote	Topamax	Detogenic Diet	Zarontin
Felbatol	Vimpat	OTHER: _____			

- Seizures consist of:

  Shaking of: (both sides, right side, left side, head trunk)

Loss of consciousness	Turning to one side	Sweating	Staring
Raising arm	Screaming	Confusion	Foaming at mouth
Head banging	Can hear but can't respond		Noisy breathing
Biting tongue	Loss of vision	Rigidity	Wetting pants
Picking at clothes	Turning pale	Smacking lips	Blinking eyes
Turning red	Flailing arms		

- After the seizure, patient is:

  Confused for _____ minutes/hours Not confused

  Weak: Both Sides Right Side Left Side Head Trunk _____

  Numb: Both Sides Right Side Left Side Head Trunk _____

  Agitated Blurred vision Headache Sleepy Can't talk right

  Irritable Depressed Angry Euphoric Other: _____

- Seizures began following:

  Head injury Car accident Meningitis Encephalitis Stroke

  Bleeding in brain High fever Drug reaction to: _____

- Are you taking any of these medications or drugs?

  Theophylline Wellbutrin/Bupropion Ultram/Ultracet/Tramadol

  Effexor/Venlafaxine Cocaine Alcohol

- Do you smell things others don't smell? Yes / No
- Have you ever had any significant head trauma? Yes / No
- Do you have a history of concussions? Yes / No
- Do you ever have Deja'VU? Yes / No
- Do you ever have Jama'Vu? Yes / No
- Do you have periods where you lose track of time? Yes / No
- Do you have episodes of anxiety for no reason? Yes / No
- Do you have vivid dreams? Yes / No
- Do you have sleep paralysis? Yes / No
- Do you have uncontrollable body movements? Yes / No