Seizure and Epilepsy Clinic
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Patient Name: _____ Date of Appointment: _____

New Patient Questionnaire

Please fill out as much of this questionnaire as you can before your appointment.

GENERAL QUESTIONS

Circle one: RH, LH, ambidextrous

Who is with you today? _____

What is your primary goal for today's visit? _____

What other physician(s) have treated you for seizures in the past? _____

Have you ever been diagnosed with epilepsy? _____

If so, have you been given a name for a specific type of epilepsy syndrome? (Examples: Juvenile Myoclonic Epilepsy, Temporal Lobe Epilepsy, Idiopathic Generalized Epilepsy, Partial or Focal Onset Epilepsy, Absence seizures, Lennox Gastaut Syndrome) _____

When was your most recent seizure? _____

What are you *currently* taking for your seizures (if anything), and who is the prescribing doctor? _____

Do you drive? _____

How did you find out about Dr. Strayhorn and the Seizure and Epilepsy Clinic at Comprehensive Neurological Services?

SEIZURE (or EVENT) DESCRIPTION

It is important to have as detailed a description of your seizures as possible, not only from your perspective, but also from the perspective of an observer. This can be accomplished by describing *individual* seizures (if you have had only one or a small number of seizures), by describing *types* of seizures (if you have had many seizures that are similar to one another), or by a mixture of both. Many people will have one type of seizure which varies in terms of severity; in this case, describe a "full-blown" seizure.

Be as detailed as possible in your descriptions. Include:

- warnings that you notice (if any) before a seizure starts
- warnings that others notice (if any) before a seizure starts
- what symptoms you experience before, during, and after a seizure
- whether your awareness or level of consciousness is altered
- how you act during a seizure from beginning to end
- whether there is shaking or trembling
- whether there is alteration of awareness or loss of consciousness
- how long a seizure typically lasts
- how you act after a seizure
- any other details you think are significant

Seizure or seizure type #1

If you have a name for this seizure type, what is it? Circle one or write in your own name:

grand mal, petite mal, convulsion, blackout, staring spell, other: _____

Description from *your* perspective. (If you have no later memory other than what other people later tell you, simply state "no memory"): _____

_____

_____

_____

Description from an *observer's* perspective. _____

_____

_____

_____

Timing:

Date of this seizure (if you have had only one): _____

If you have had more than one, provide:

Date of the *first* seizure: _____ Date of *most recent* seizure _____

State the frequency of this type of seizure; alternatively, state the total number of this type of seizure: _____

Triggers:

Do you know of any ways to trigger your seizures? Circle any triggers from the following list, write any triggers not in the list, and elaborate in the space provided. stress, sleep deprivation, flashing lights, alcohol consumption or alcohol withdrawal, menstrual period, time of day or night, hyperventilation. _____

_____

_____

Seizure or seizure type #2

If you have a name for this seizure type, what is it? Circle one or write in your own name:

grand mal, petite mal, convulsion, blackout, staring spell, other: _____

Description from *your* perspective. (If you have no later memory other than what other people later tell you, simply state "no memory"): _____

_____

_____

_____

Description from an *observer's* perspective. _____

_____

_____

_____

Timing:
Date of this seizure (if you have had only one): _____
If you have had more than one, provide:
Date of the *first* seizure: _____ Date of *most recent* seizure _____
State the frequency of this type of seizure; alternatively, state the total number of this type of seizure: _____

Triggers:
Do you know of any ways to trigger your seizures? Circle any triggers from the following list, write any triggers not in the list, and elaborate in the space provided. stress, sleep deprivation, flashing lights, alcohol consumption or alcohol withdrawal, menstrual period, time of day or night, hyperventilation. _____

_____

_____

Seizure or seizure type #3
If you have a name for this seizure type, what is it? Circle one or write in your own name:
grand mal, petite mal, convulsion, blackout, staring spell, other: _____

Description from *your* perspective. (If you have no later memory other than what other people later tell you, simply state "no memory"): _____

_____

_____

_____

Description from an *observer's* perspective. _____

_____

_____

_____

Timing:
Date of this seizure (if you have had only one): _____
If you have had more than one, provide:
Date of the *first* seizure: _____ Date of *most recent* seizure _____
State the frequency of this type of seizure; alternatively, state the total number of this type of seizure: _____

Triggers:
Do you know of any ways to trigger your seizures? Circle any triggers from the following list, write any triggers not in the list, and elaborate in the space provided. stress, sleep deprivation, flashing lights, alcohol consumption or alcohol withdrawal, menstrual period, time of day or night, hyperventilation. _____

_____

_____

SEIZURE SYMPTOMS

Do you experience any of the following symptoms, either during a seizure or otherwise?

Y N

☐☐ **staring spells** (Only consider spells that are out of the range of what you would consider to be commonplace or normal. For instance, everyone can daydream from time to time.) _____

☐☐ **olfactory hallucinations** (This refers to smells that you have good reason to suspect may not be "real" smells because other people cannot detect them and you cannot identify a source of the smell.) If yes, are there any associated emotions or memories? _____

☐☐ **déjà vu** or other abnormal memory symptoms (A feeling that you have experienced something before when such is not actually the case.) _____

☐☐ **autonomic symptoms** (Examples include: changes in heart rate, sweating, flushing, abnormal breathing) _____

☐☐ **epigastric rising** (Do you have a warm feeling in your stomach, feel nauseated, or get butterflies in your stomach?) _____

☐☐ **myoclonus** (This refers to isolated twitches or jerking movements.) _____

☐☐ **lost time** (This refers to gaps in your memory that you cannot explain.) _____

☐☐ **oral trauma** (Do you bite your tongue or the inside of your cheek, either during a seizure or while you were sleeping?) _____

☐☐ **incontinence** (Do you lose control of your bladder or bowels either during a seizure or while you are asleep?) _____

☐☐ **derealization** (Do you have "out of body" sensations or feel like you are floating or observing yourself from a distance?) _____

☐☐ **chest pain** _____

☐☐ **palpitations** _____

☐☐ **orthostasis** (Do you sometimes get dizzy, lightheaded, or feel like you may pass out when you stand? Are these symptoms made better by sitting or lying down?) _____

SEIZURE RISK FACTORS

To the best of your knowledge, do you have a history of any of the following?

Comments

Y N

☐☐ family history of seizures or epilepsy _____

☐☐ febrile seizures (convulsions with a fever when you were a baby) _____

☐☐ head injury for which you received treatment (or think you should have received treatment if you didn't) _____

☐☐ meningitis or encephalitis _____

☐☐ stroke _____

☐☐ brain tumor _____

☐☐ sexual abuse _____

☐☐ alcohol abuse _____

☐☐ any other potential causes of seizures _____

DIAGNOSTIC TESTING

Indicate whether you have or have not had any of the following tests and if so, indicate relevant information in the comments (when, who performed, result).

Comments

EEG: (electroencephalogram; recordings from 21 to 25 electrodes on your scalp which measure the brain's electrical activity)

Y N

☐☐ routine EEG (an EEG that typically takes no more than an hour or two to complete) _____

☐☐ ambulatory EEG (an outpatient EEG that lasts overnight; may be with or without video) _____

☐☐ Epilepsy Monitoring Unit (a prolonged video EEG performed as an inpatient) _____

Imaging:

Y N

☐☐ head CT (computed tomography; uses X-rays; typically takes just a few minutes to complete) _____

☐☐ brain MRI (magnetic resonance imaging; usually performed in a small tube and triggers claustrophobia in some people; takes longer than a CT and is generally more noisy) _____

Specialized testing:

Y N

☐☐ SPECT (single-photon emission computed tomography) _____

☐☐ PET (positron emission tomography) _____

☐☐ WADA (intracarotid sodium amobarbital procedure) _____

☐☐ Neuropsychological evaluation _____

☐☐ Any other relevant testing _____

SEIZURE TREATMENT HISTORY

CURRENT SEIZURE TREATMENTS:
Indicate what medications you are currently taking for seizures. Include as much of the following as you are able: when you started the medication, the current dose, how well it is working, and side effects.

Drug Name	Dose	Side Effects (if any)	Effectiveness

Y N
☐☐ birth control
☐☐ folate
☐☐ vitamin D
☐☐ calcium

PRIOR TREATMENTS:
Circle (or indicate using the checkboxes) which of the following medications you have been on in the past. Cross out the ones you have never taken. To the best of your ability, include the following pieces of information: date started and date stopped, maximum dose, how well it worked, side effects, and any other pertinent information.

Y N	generic	brand names	Comments
☐☐	lorazepam	Ativan	
☐☐	acetazolamide	Diamox	
☐☐	carbamazepine	Tegretol	
☐☐	carbamazepine	Carbatrol	
☐☐	clobazam	Onfi	
☐☐	clonazepam	Klonopin	
☐☐	clorazepate	Tranxene	
☐☐	diazepam	Valium	
☐☐	diazepam rect	Diastat	
☐☐	divalproex sodium	Depakote	
☐☐	ethosuximide	Zarontin	
☐☐	felbamate	Felbatol	
☐☐	gabapentin	Neurontin	
☐☐	lacosamide	Vimpat	
☐☐	lamotrigine	Lamictal	
☐☐	levetiracetam	Keppra	
☐☐	oxcarbazepine	Trileptal	
☐☐	phenobarbital		
☐☐	phenytoin	Dilantin	
☐☐	pregabalin	Lyrica	
☐☐	primidone	Mysoline	
☐☐	rufinamide	Banzel	
☐☐	tiagabine	Gabitril	
☐☐	topiramate	Topamax	
☐☐	valproate sodium	Depacon	
☐☐	valproic acid	Depakene	
☐☐	vigabatrin	Sabril	

☐☐ zonisamide Zonegran _____

☐☐ Brain surgery _____
☐☐ Vagal Nerve Stimulator _____
☐☐ Ketogenic Diet _____

☐☐ Acupuncture _____
☐☐ Meditation _____
☐☐ Hypnosis _____

☐☐ other _____

GENERAL INFORMATION

MEDICATIONS (not seizure related and not indicated elsewhere on this form)

Drug Name	Dose	Side Effects (if any)	Purpose

Are you allergic to any drugs? If so, please list them here:

Drug Name	Allergy

PAST MEDICAL HISTORY (not seizure related and not indicated elsewhere on this form)

Diagnoses, chronic illnesses or other medical problems:

Surgeries:

Hospitilizations:

FAMILY MEDICAL HISTORY

Y N		Relationship	Comments
☐☐	Parkinson's disease or other movement disorder		
☐☐	Alzheimer's disease or other dementia		
☐☐	Migraine		
☐☐	Cancer		
☐☐	Heart attack at an early age		
☐☐	Stroke at an early age		
☐☐	Obstructive sleep apnea		
☐☐	Other (list here)		

SOCIAL HISTORY:

What is your marital status? _____

Do you have children? _____

What is the highest level of education you have received? _____

What is your occupation? (include whether you are a student, disabled, retired, etc) _____

Did you have a drink containing alcohol in the past year? ☐ Yes ☐ No

If yes:

How often?

☐ Never ☐ monthly or less ☐ 2-4 times per month

☐ 2-3 times per week ☐ 4 or more times a week

How many drinks did you have on a typical day when you were drinking?

☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-9 ☐ 10 or more

How often did you have 6 or more drinks on one occasion in the past?

☐ Never ☐ less than monthly ☐ monthly ☐ weekly ☐ daily or almost daily

Are you a ☐ current smoker ☐ former smoker ☐ never smoker

If current smoker:

How often do you smoke cigarettes?

☐ every day ☐ some days, but not every day

How many cigarettes a day do you smoke?

☐ 5 or less ☐ 6-10 ☐ 11-20 ☐ 21-30 ☐ 31 or more

How soon after you wake up do you smoke your first cigarette?

☐ within 5 min ☐ 6-30 min ☐ 31-60 min ☐ after 60 min

Are you interested in quitting?

☐ ready to quit ☐ thinking about quitting ☐ not ready to quit

If former smoker:

How long has it been since you last smoked?

☐ 1-3 months ☐ <1 month ☐ <1 month ☐ 3-6 months

☐ 6-12 months ☐ 1-5 years ☐ 5-10 years ☐ > 10 years