

General Neurology Clinic
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Seizure/Epilepsy Follow-up Visit Questionnaire

Patient's Name: _____ Today's Date: _____

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

Who is with you today? _____

Do you have any particular questions, or concerns you would like to address today? _____

Have you had any seizures since your last visit? _____ Yes _____ No

When was your most recent seizure? If you have more than one type of seizure (for example convulsions and staring spells), answer for each seizure type individually. Use the back of this sheet, if necessary.

Seizure #1: Date of most recent _____ Overall frequency (estimation): _____

Seizure description:

Seizure #2: Date of most recent _____ Overall frequency (estimation): _____

Seizure description:

What are you currently taking for your seizures? Include doses and side effects (if any):

Have you had any other medical developments since you last visit? (New diagnoses, medication changes, etc.):

Do you drive? _____ Yes _____ No