

# 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 / YY | Height <input type="checkbox"/> M <input type="checkbox"/> Ft | Weight <input type="checkbox"/> Kg <input type="checkbox"/> Lb |

## 2. MEDICAL INFORMATION

|                           |           |
|---------------------------|-----------|
| Date of first symptom     | Symptoms  |
| MM / DD / YY              |           |
| Date of last consultation | Diagnosis |
| MM / DD / YY              |           |

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

|                                  |                   |  |
|----------------------------------|-------------------|--|
| Diagnostic method                | Details           |  |
| <input type="checkbox"/> CT scan | Result            |  |
|                                  | Treatment         |  |
| Date                             | Prognosis         |  |
| MM / DD / YY                     | Current condition |  |

|   |                   |  |
|---|-------------------|--|
| Diagnostic method                       | Details           |  |
| <input type="checkbox"/> MRI            | Result            |  |
|   | Treatment         |  |
| Date                                    | Prognosis         |  |
| MM / DD / YY                            | Current condition |  |
| Diagnostic method                       | Details           |  |
| <input type="checkbox"/> EEG            | Result            |  |
|   | Treatment         |  |
| Date                                    | Prognosis         |  |
| MM / DD / YY                            | Current condition |  |
| Diagnostic method                       | Details           |  |
| <input type="checkbox"/> Arteriography  | Result            |  |
|   | Treatment         |  |
| Date                                    | Prognosis         |  |
| MM / DD / YY                            | Current condition |  |
| Diagnostic method                       | Details           |  |
| <input type="checkbox"/> Tumor excluded | Result            |  |
|   | Treatment         |  |
| Date                                    | Prognosis         |  |
| MM / DD / YY                            | Current condition |  |
| Diagnostic method                       | Details           |  |
| <input type="checkbox"/> Other          | Result            |  |
|   | Treatment         |  |
| Date                                    | Prognosis         |  |
| MM / DD / YY                            | Current condition |  |

### 3. TREATING PHYSICIAN'S INFORMATION

|           |  |      |              |
|-----------|--|------|--------------|
| Name      |  |      |              |
| Address   |  |      |              |
| Telephone |  | Fax  |              |
| Email     |  |      |              |
| Signature |  | Date | MM / DD / YY |