

# 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"/> Simple <input type="checkbox"/> Complex	<input type="checkbox"/> Primary (idiopathic) <input type="checkbox"/> Secondary
II. Generalized <input type="checkbox"/> Absence seizures <input type="checkbox"/> Myoclonic <input type="checkbox"/> Tonic - Clonic <input type="checkbox"/> Clonic <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