

EPILEPSY QUESTIONNAIRE

Patient Name: _____ Sex: _____ Age: _____ Date: _____

Referring Physician: _____ Family Physician (PCP): _____

Please complete the following questionnaire by filling in the blanks and placing a check in appropriate areas.

Seizure History

How long have you had seizures? _____

Date of first seizure: _____ Date of last seizure: _____

How often do you have seizures? _____

Have you ever been hospitalized because of seizures? Yes No

If yes, please provide details regarding dates, duration of stay, and treatment received:

Any risk factors for seizures:

Birth Injury	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Head Injury	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Febrile Seizure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Prior Neurosurgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

If you answered yes to any of the above risk factors, please explain:

Please indicate type of seizures and frequency:

Simple Partial	Frequency/week	Absence (staring spells)	Frequency/week
Complex Partial (petit mal)	_____	Atonic (drop seizure)	_____
Generalized Tonic-Clonic (grand mal)	_____	Tonic (stiffening seizures)	_____
Myoclonic (jerks)	_____	Any other type _____	_____

Can you tell if you are about to have a seizure? Yes No

If yes, please explain:

Please describe details of your symptoms when you have a seizure:

Are you taking medications for seizures? Yes No

Medication	Dose	# Times Per Day		Medication	Dose	# Times Per Day

Please list all seizure medications you have tried previously:

If you have any side effects to previous seizure medications, please explain:

Please list any allergies to medications:

MEDICAL HISTORY

Past Medical History

- | | | |
|--|--|---|
| <input type="checkbox"/> Hypertension (<i>High Blood Pressure</i>) | <input type="checkbox"/> Blackouts | <input type="checkbox"/> Chemical dependency or abuse |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Seizures | Female |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Back or Joint problems (<i>Arthritis</i>) | <input type="checkbox"/> Premenstrual Syndrome |
| <input type="checkbox"/> Stomach or Colon problems | <input type="checkbox"/> Cancer | <input type="checkbox"/> Menopause |
| <input type="checkbox"/> Lung problems/COPD/Asthma | <input type="checkbox"/> Thyroid problems | Male |
| <input type="checkbox"/> Reflux | <input type="checkbox"/> Hepatitis/Jaundice | <input type="checkbox"/> Prostate problems |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Hearing impairment | <input type="checkbox"/> Erectile Dysfunction/Impotence |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Depression or Severe Anxiety | |
| <input type="checkbox"/> TIA " <i>Light Stroke</i> " | <input type="checkbox"/> Alcoholism | |

List other past medical problems and dates:

_____	_____
_____	_____
_____	_____

List surgeries and the year:

_____	_____
_____	_____
_____	_____
_____	_____

Social History

Marital Status: Single Married Separated Divorced Widowed

Sleep alone Share a bedroom, but have separate beds
 Share a bed with someone Share a dwelling, but have separate bedrooms

Employment Status: Employed Unemployed Retired

My job requires driving a vehicle I am a permanent or long term third shift worker
 I work with dangerous equipment or substances I am currently a student
 I am a shift worker on rotating shifts

Habits:

Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If Yes:	What	Amount Per Day	For How Many Years
<input type="checkbox"/>	Cigarettes	_____ pack(s)	_____
<input type="checkbox"/>	Cigars	_____ cigars	_____
<input type="checkbox"/>	Tobacco	_____ pipes	_____

Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If Yes:	What	Frequency	Amount Per Week
<input type="checkbox"/>	Beer	<input type="checkbox"/> Daily <input type="checkbox"/> Weekends <input type="checkbox"/> Rare	_____ cans
<input type="checkbox"/>	Wine	<input type="checkbox"/> Daily <input type="checkbox"/> Weekends <input type="checkbox"/> Rare	_____ glasses
<input type="checkbox"/>	Liquor	<input type="checkbox"/> Daily <input type="checkbox"/> Weekends <input type="checkbox"/> Rare	_____ shots

Family History:

Has an immediate blood relative had any of the following?

Yes	No	Thyroid Disease	Relation
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	_____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	_____
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	_____
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	_____

Yes	No	Relation
<input type="checkbox"/>	<input type="checkbox"/>	Stroke _____
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety/Depression _____
<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea _____
<input type="checkbox"/>	<input type="checkbox"/>	Narcolepsy _____
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

Review of Systems

In the PAST 12 MONTHS, check any of the following symptoms you have had:

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>	Frequent heartburn or indigestion
<input type="checkbox"/>	<input type="checkbox"/>	Fainting or passing out	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal pain
<input type="checkbox"/>	<input type="checkbox"/>	Sudden loss of vision or strength, or inability to speak	<input type="checkbox"/>	<input type="checkbox"/>	Frequent constipation
<input type="checkbox"/>	<input type="checkbox"/>	Hearing loss or ringing in ear(s)	<input type="checkbox"/>	<input type="checkbox"/>	Frequent diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness for more than 2-4 weeks	<input type="checkbox"/>	<input type="checkbox"/>	Rectal bleeding / black stools
<input type="checkbox"/>	<input type="checkbox"/>	Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty urinating / incontinence

Review of Systems (continued)

- | | | | | | |
|--------------------------|--------------------------|--|--------------------------|--------------------------|---------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Cough for more than 2-4 weeks | <input type="checkbox"/> | <input type="checkbox"/> | Blood in urine |
| <input type="checkbox"/> | <input type="checkbox"/> | Coughing up blood | <input type="checkbox"/> | <input type="checkbox"/> | Urinating more than 2 times per night |
| Yes | No | | Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath or wheezing | <input type="checkbox"/> | <input type="checkbox"/> | Pain in joints or bones |
| <input type="checkbox"/> | <input type="checkbox"/> | Swelling in feet or ankles | <input type="checkbox"/> | <input type="checkbox"/> | Unusual bleeding or bruising |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest pain, chest pressure or heaviness | <input type="checkbox"/> | <input type="checkbox"/> | Convulsions |
| <input type="checkbox"/> | <input type="checkbox"/> | Irregular heartbeat or sudden fast heartbeat | <input type="checkbox"/> | <input type="checkbox"/> | Change in wart, mole or skin growth |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty swallowing or food "sticking" | <input type="checkbox"/> | <input type="checkbox"/> | Weight loss of more than 5-10 lbs. |

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

0 = would *never* doze

1 = *slight* chance of dozing

2 = *moderate* chance of dozing

4 = *high* chance of dozing

Situation

Chance of Dozing

Sitting and reading

Watching TV

Sitting inactive in a public place (e.g. a theater or meeting)

As a passenger in a car for an hour without a break

Lying down to rest in the afternoon when circumstances permit

Sitting and talking to someone

Sitting quietly after a lunch without alcohol

In a car, while stopped for a few minutes in the traffic

Total:

Do you:

Never

Occasionally

Often

Always

1. Fall asleep or get sleepy when:

a. Driving?

0

1

2

3

b. At work?

0

1

2

3

2. Do you take intentional naps?

0

1

2

3

3. Do you experience periods of muscle weakness or loss of muscle control with laughter or excitement?

0

1

2

3

4. Do you experience vivid dreamlike episodes when falling asleep?

0

1

2

3

5. Do you feel unable to move when falling asleep?

0

1

2

3