CTNC Central Texas Neurology Consultants

Diseases of the Brain, Spine, Nerves and Muscles

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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	☐ Yes	☐ No	Head Injury	☐ Yes	☐ No
Febrile Seizure	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Prior Neurosurgery	☐ Yes	☐ No			

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

Please indicate type of seizures and frequency:

	Frequency/week		Frequency/week
Simple Partial	_____	Absence (staring spells)	_____
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

☐ Hypertension (*High Blood Pressure*)
☐ Heart Disease
☐ Diabetes
☐ Stomach or Colon problems
☐ Lung problems/COPD/Asthma
☐ Reflux
☐ Fibromyalgia
☐ Stroke
☐ TIA *"Light Stroke"*
☐ Blackouts
☐ Seizures
☐ Back or Joint problems (*Arthritis)*
☐ Cancer
☐ Thyroid problems
☐ Hepatitis/Jaundice
☐ Hearing impairment
☐ Depression or Severe Anxiety
☐ Alcoholism
☐ Chemical dependency or abuse

Female
☐ Premenstrual Syndrome
☐ Menopause

Male
☐ Prostate problems
☐ Erectile Dysfunction/Impotence

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

Employment Status: ☐ Employed ☐ Unemployed ☐ Retired

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

Habits:

Do you smoke? ☐ Yes ☐ No

If Yes: What	Amount Per Day	For How Many Years
☐ Cigarettes	_____ pack(s)	
☐ Cigars	_____ cigars	
☐ Tobacco	_____ pipes	

Do you drink alcohol? ☐ Yes ☐ No

If Yes: What	Frequency	Amount Per Week
☐ Beer	☐ Daily ☐ Weekends ☐ Rare	_____ cans
☐ Wine	☐ Daily ☐ Weekends ☐ Rare	_____ glasses
☐ Liquor	☐ Daily ☐ Weekends ☐ Rare	_____ shots

Family History:

Has an immediate blood relative had any of the following?

Yes	No	Thyroid Disease	Relation
☐	☐	Cancer	
☐	☐	Diabetes	
☐	☐	Hypertension	
☐	☐	Heart Disease	
☐	☐	Thyroid Disease	

Yes	No		Relation
☐	☐	Stroke	
☐	☐	Anxiety/Depression	
☐	☐	Sleep Apnea	
☐	☐	Narcolepsy	
☐	☐	Other: _____	

Review of Systems

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

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

Review of Systems (continued)

Yes	No		Yes	No	
☐	☐	Cough for more than 2-4 weeks	☐	☐	Blood in urine
☐	☐	Coughing up blood	☐	☐	Urinating more than 2 times per night
☐	☐	Shortness of breath or wheezing	☐	☐	Pain in joints or bones
☐	☐	Swelling in feet or ankles	☐	☐	Unusual bleeding or bruising
☐	☐	Chest pain, chest pressure or heaviness	☐	☐	Convulsions
☐	☐	Irregular heartbeat or sudden fast heartbeat	☐	☐	Change in wart, mole or skin growth
☐	☐	Difficulty swallowing or food "sticking"	☐	☐	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)

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