Epilepsy Questionnaire

Name:	
DOB:	Today's Date:

Onset:

1) At what age did you start having seizures?

Frequency, Duration and History:

2) How often do your seizures occur? Please note days, months etc.

	YES/NO	DETAILS
3) Do you lose consciousness during each seizure?		
4) Have you ever bitten your tongue during a seizure?		
5) Have you ever lost bladder control during the seizure?		
6) Have you ever suffered an injury during a seizure?		

7) How long does a typical seizure last? (use chart below)

0-30 Seconds	30-60 Seconds	60-90 Seconds	Minutes (how many)	Hours

8) Have you had any of the following tests?

Test type	YES/NO	When	Where
MRI	YES NO		
EEG	YES NO		
CT Scan	YES NO		

9) Please indicate if you have had the following:

Condition	YES/ NO	Details (dates, loss of consciousness etc.)
Stroke	YES NO	
Head injury	YES NO	
Meningitis or Encephalitis	YES NO	
Family history of seizures	YES NO	

Associated Symptoms and Treatment History :

10) Please circle all symptoms that apply to your typical seizure.

Headache	Muscle aches	Confusion following seizure (if yes, how long?)
Fatigue	Nausea/vomiting	Other:

11) Are you aware of anything that triggers your seizures?

Yes	**No**

If yes, please describe:

12) Please note all medication taken for seizures

Medication Name		**Max dose reached**	**Reason for stopping medication**
Banzel	○		
Carbamazepine	○		
Clonazepam	○		
Depakote	○		
Dilantin/ Phenytoin	○		
Felbatol	○		
Gabapentin (Neurontin)	○		
Gabitril	○		
Keppra (Levetiracetam)	○		
Lamotrigine	○		
Lyrica (Pregabalin)	○		
Oxycarbazepine	○		
Phenobarbitol	○		
Topiramate	○		
Vimpat (Lacosamide)	○		
Other:			
Other:			