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**Seizure Questionnaire**

Date of Visit: \_\_\_\_\_ Patient: \_\_\_\_\_

**By answering the following questions, you will help your physician better understand and treat your seizures.**

When did your seizures first start? \_\_\_\_\_

When was the last time your had a seizure? \_\_\_\_\_

Do you have more than one type of seizure? \_\_\_\_\_

Are your seizures worse now? \_\_\_\_\_ When did your seizures become more severe? \_\_\_\_\_

How often do you have seizures now? (Estimate) \_\_\_\_\_

Do any of your relatives also have seizures? \_\_\_\_\_ If yes, who? \_\_\_\_\_

**What doctors have you seen? When did you see them? What did they do? (example: Dr. A.B. Smith, October 2008, Ordered MRI, Prescribed –name medication)**

Doctor's Name	Month/Year Seen	What was done?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**What tests and studies have been done? (example: MRI, CT-Scan, EEGs)**

Name of Test	Month/Year Seen	Results
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**These things are sometimes associated with seizures. Please circle if any apply to you.**

- |  |                                      |              |
|--|--------------------------------------|--------------|
| Severe head injury                       | Alcohol withdrawal symptoms          | Meningitis   |
| Trouble remembering to take seizure Meds | Drug Use                             | Stroke       |
| Aneurysm                                 | Brain Bleed                          | Brain Tumor  |
| Other family members have seizures       | Anxiety                              | Depression   |
| Febrile seizures as an infant            | Women: Problems related to pregnancy | Encephalitis |

