Questionnaire for Seizure Patient

Please complete all questions in their entirety to the best of your knowledge. The requested information is essential for the NorthShore University HealthSystem staff in determining the most efficient care plan.

Patient's Name Date of Birth

Seizure Information

1. What is the main concern that you would like addressed today?
____
____
2. When was the first event of concern?
____
____
Please describe the event (how long it lasted, etc…) :
____
____
3. Have all of the events been the same? Yes or No If no, please describe all of the events: ____________________________________
____
____
4. How did you behave after the event?
____
____
5. How many times has this happened?
____
____
6. Have you previously seen a neurologist for this issue? Yes or No
7. Have you been on medications for this in the past? Yes or No
8. What treatments/medications have you tried (please include dosage)? Do they work?
____
____

Past History: Has previous brain imaging (MRI or CT) been performed? Yes or No

Has an EEG been performed? Yes or No

Is there a Family History of seizures? Yes or No If so, please explain:
____
____