ASSOCIATED NEUROLOGICAL SPECIALTIES

Robert M. Cain, MD

Phone (512) 458-2600
Fax (512) 454-2292

Patient Name:_____ Today's Date:_____

CHIEF COMPLAINT-EPILEPSY

1. When was your last seizure?

2. Describe your last seizure.

3. How long was the seizure?

4. Were the eyes opened or closed?

5. Did one side seem more involved than the other?

6. Did you bite your tongue with the seizure? Did you have any other injury from the seizure?

7. Did you lose your urine?

8. Can you tell the seizure is coming?

9. Do you have an aura or warning? _____ If so, describe.

10. What is the longest seizure you have ever had?

11. What happens after the seizure?

CHIEF COMPLAINT-EPILEPSY CONTINUED:

12. When was your first seizure in your life?

13. Do you know how many seizures you have had in your life?

14. Is there a family history of epilepsy or seizure?

15. Do you have a history of serious head trauma?

16. Did you have seizures as a child with fever?

17. Have you ever been on medication for seizures? _____ If so, what medication? List medications and response to treatment.

    a. Dilantin
    b. Tegretol
    c. Depakote
    d. Phenobarbital
    e. Keppra
    f. Lamictal
    g. Trileptal
    h. Topomax
    i. Zonegran
    j. Other

18. Are you allergic to any anticonvulsant medication?

19. Have you had any adverse responses to anticonvulsant medication?

If yes, which medication and what were the side effects?

20. Is there a trigger for these seizures that you have identified?

CHIEF COMPLAINT-EPILEPSY CONTINUED:

21. What do you think is the cause of these seizures?

22. Do you know that you cannot drive for six months following a seizure?

23. What specific questions do you have about seizures and epilepsy?

24. Have you had an MRI scan or a CT scan of the brain?

If yes, what was the result of the scan?

Where did you have the scan?

25. Have you had an EEG?

If so, what was the result?

Where did you have the scan?