Child Neurology SOLUTIONS

New Patient Questionnaire - Epilepsy

Patient Name:_____DOB: _____

Person completing this form:_____Relationship: _____
(if other than the patient)

GENERAL SEIZURE HISTORY

When do you think your child had their first seizure?	
When was the last time they had a seizure?	
What is the longest that your child has been seizure-free?	
Does your child have clusters of seizures?	
Has your child ever been admitted to a hospital for seizures? How often?	
Has your child ever had continuous seizures for over 30 minutes (status epilepticus)? How often?	
Has your child ever been injured during a seizure? If so, please describe the injury.	
Has your child's seizures changed in frequency, duration, and/or severity recently?	
What is your goal for this evaluation?	

New Patient Questionnaire – Epilepsy (page 2)

Patient Name:_____DOB: _____

Please list the names, addresses, and phone numbers of the doctors who have treated your seizures. Attach another sheet if necessary.	

SEIZURE TYPES AND DESCRIPTIONS

Please answer the questions based on what you have seen and what other people have told you happens. Please complete one table for each of seizure types.

Seizure type #1 (A)	**Describe these events**:
How old was your child when they started to have these events?	
How long does each seizure usually last?	
How many seizures has your child had of this type? (about)	
Are there any warning signs/auras at the beginning of these seizures? (e.g. dizziness, fear, headache, déjà vu, laughter, inability to speak, twitching or other movements, etc.)	
Is there anything that triggers these seizures? (e.g. stress, lights, fatigue, menstrual periods, etc.)	
Do these seizures come in clusters?	
Do these seizures occur at any particular time of day? (e.g. during sleep, when first awakens, etc.)	
When was the last time your child had this type of seizure?	

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Seizure type #2 (B)	**Describe these events**:
How old was your child when they started to have these events?	
How long does each seizure usually last?	
How many seizures has your child had of this type? (about)	
Are there any warning signs/auras at the beginning of these seizures? (e.g. dizziness, fear, headache, déjà vu, laughter, inability to speak, twitching or other movements, etc.)	
Is there anything that triggers these seizures? (e.g. stress, lights, fatigue, menstrual periods, etc.)	
Do these seizures come in clusters?	
Do these seizures occur at any particular time of day? (e.g. during sleep, when first awakens, etc.)	
When was the last time your child had this type of seizure?	

Seizure type #3 (C)	**Describe these events:**
How old was your child when they started to have these events?	
How long does each seizure usually last?	
How many seizures has your child had of this type? (about)	
Are there any warning signs/auras at the beginning of these seizures? (e.g. dizziness, fear, headache, déjà vu, laughter, inability to speak, twitching or other movements, etc.)	
Is there anything that triggers these seizures? (e.g. stress, lights, fatigue, menstrual periods, etc.)	

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Do these seizures come in clusters?	
Do these seizures occur at any particular time of day? (e.g. during sleep, when first awakens, etc.)	
When was the last time your child had this type of seizure?	

RISK FACTORS FOR SEIZURES

Were there any prenatal or labor and delivery problems surrounding your child's birth?	
Has your child had any head injuries?	
Has your child had any other brain problems? (stroke, brain tumor, learning problems, weakness, etc.)	
Did your child ever have a seizure with a high fever when a baby?	
Has anyone in your family ever had seizures?	

PAST MEDICAL HISTORY

Does your child have (or have they had) any of the following medical conditions? (Please circle all that apply)

Migraines/ headaches Depression/Anxiety Heart Problems Irregular Heart Beat

Kidney Stones Liver disease Vision problems (describe) _____

Cancer (type/location)_____-_____

For teenage girls: Are their menstrual periods regular? (circle) Yes No If not, explain _____

PREVIOUS EPILEPSY WORK-UP

Please indicate when and where your child had these tests done. If they have had a test done more than once, please list when and where each test was performed. If you are aware of the results, please indicate. Attach additional sheets if necessary. If you have not had a particular test, just write "N/A".

Routine EEG (no video)	
VideoEEG monitoring – Please indicate if seizures were recorded.	

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MRI of the brain	
CT of the brain	
Neuropsychological testing	
Lumbar puncture	
Any other tests related to your seizures (e.g. magnetoencephalography, SPECT scan)	

CURRENT SEIZURE MEDICATIONS

Name of Medication	Generic? (Y or N)	Number of mg per pill	Number of pills per dose					Total number of mg per day
			a.m.	Noon	After-noon	Evening	Bedtime	

Do you have rescue medications to give your child either for long seizures or to stop a cluster of seizures? (circle) Yes No If yes, what medication?_____Dose? _____mg
After how many seizures do you give rescue medication to your child? _____

PREVIOUS EPILEPSY TREATMENTS

Previous Seizure Medications

Place a check mark beside each seizure medication you have taken in the past. If you have a taken a particular medication, indicate the highest dose used, and why the medication was stopped.

Name of Medication	When (about)	Highest Dose (mg)	Why Medication Was Stopped	
			Didn't work	Side Effects (Please list)
Carbamazepine (Tegretol)				
Ezogabine (Potiga)				
Gabapentin (Neurontin)				

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Lacosamide (Vimpat)				
Lamotrigine (Lamictal)				
Levetiracetam (Keppra)				
Oxcarbazepine (Trileptal)				
Phenobarbital				
Phenytoin (Dilantin)				
Pregabalin (Lyrica)				
Tiagabine (Gabitril)				
Topiramate (Topamax)				
Rufinamide (Banzel)				
Valproic Acid (Depakote/Depakene)				
Vigabatrin (Sabril)				
Zonisamide (Zonegran)				

Previous Surgical Treatment for Epilepsy

Vagus Nerve Stimulator

Have you ever had a vagus nerve stimulator (VNS) implanted?____Yes_____No If yes:
When was it implanted and at what hospital? _____
_____
Has the VNS reduced your seizure frequency?____Yes_____No
If yes, were you able to reduce your seizure medications?_Yes___No
Are you able to stop a seizure or seizure cluster using your magnet?___Yes___No Are you experiencing any side effects from your VNS? If so, please describe.
_____
Have the VNS settings been adjusted to improve seizure control/reduce side effects?____Yes____No Have you ever had the VNS replaced because the battery ran out?_____Yes____No If yes, when was your VNS last replaced? _____

Epilepsy Brain Surgery

Have you ever had brain surgery for your epilepsy?____Yes_____No If yes:
When and where was the surgery performed? _____
_____
_____

Type of surgery:_____Temporal lobectomy: ____Right_____Left
_____ Removal of mass/tumor
_____ Removal of seizure focus identified by recording seizures using depth

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electrodes and/or subdural grids

Was the surgery successful?_____Yes_____No

If yes, did it eliminate your seizures temporarily?____Yes____No

Decrease your seizure frequency?_____Yes____No Decrease seizure severity?_____Yes___No

_____

_____

QUALITY OF LIFE

Have your child's seizures interfered with:

_____School ____ Play _____ Sleep _____Relationships

Has your child's medication affected their learning? (circle) No Yes Behavior? No Yes Sleep? No Yes

Please describe how other aspects of your life and the lives of other members of your family are affected by your child's seizures.

_____

_____

_____