Baylor Scott & White
NEUROLOGY
MCKINNEY

Seizure Questionnaire

Have you had more than one spell: no yes, If yes:

At what age did they start: _____ and are all your spells the same: no yes

Describe each of your spell types, if any warning, and how often you have them:

1. _____
2. _____
3. _____
4. _____

Any spells associated with: trauma? no yes, If yes what did you injure?

_____

Tongue bites: no yes

Incontinence: no yes, if yes: Urine Bowels

What Medications have you taken in the past for your spells and why were they stopped:

_____

_____

Any Epilepsy Brain Surgery no yes, If yes, what surgery? when?

Any EEG Monitoring no yes, If yes, what results were you told? when?

Any MRI's of the Brain: **d** no **d**yes, If yes, what results were you told? when?

Ever have a: PET scan: no yes / VNS: no yes / Wada no yes

Name: DOB: Date