Name:_____ Date:_____

Seizure Questionnaire

At what age did your seizures begin?	_____	
How often do you have your typical seizures?	_____	
When was the most recent seizure?	_____	
How long does each seizure last on average?	_____	
Have these seizures been worsening?	Yes	No
Are these seizures disabling?	Yes	No
Do you have a history of febrile seizures?	Yes	No
Do you have a history of infantile seizures?	Yes	No
Do you have a family history of seizures?	Yes	No
Do you have a history of central nervous system infections?	Yes	No
Do you have a history of head trauma with loss of consciousness?	Yes	No
Do you have brief jerks of the arms or legs in the morning?	Yes	No
Does fatigue or sleep deprivation worsen the events?	Yes	No
Does emotional stress worsen the events?	Yes	No
Do menstrual periods worsen the events (if applicable)?	Yes	No
Is there a warning prior to the seizures?	Yes	No
Do you stop what you are doing when the seizure starts?	Yes	No
Do your eyes roll up or to the side?	Yes	No
Do you smack your lips during the seizures?	Yes	No
Do you pick at clothes or other items during the seizures?	Yes	No
Is there jerking one arm or leg or one side of the face?	Yes	No
If so, which side?	Right	Left
Is there jerking of both arms and legs?	Yes	No
Do you lose control of your bladder during the seizures?	Yes	No
Have you bitten your tongue during the seizures?	Yes	No
Are you confused after the seizures?	Yes	No
Are you sleepy after the seizures?	Yes	No
Can you remember things that happen during the seizures?	Yes	No