SEIZURES QUESTIONNAIRE

To be completed by the treating physician
(PLEASE USE BLOCK LETTERS)

Bupa

1. PATIENT'S INFORMATION

Name	Last	First	M.I.		
Date of birth	MM / DD / YY	Height ☐ M ☐ Ft		Weight ☐ Kg ☐ Lb	

2. MEDICAL INFORMATION

Date of first symptom	Symptoms
MM / DD / YY	
Date of last consultation	Diagnosis
MM / DD / YY	

Type of seizure			Etiology
I. Partial (focal)	☐ Simple	☐ Complex	☐ Primary (idiopathic) ☐ Secondary
II. Generalized	☐ Absence seizures ☐ Myoclonic ☐ Tonic - Clonic	☐ Clonic ☐ Tonic	

Associated with:	
☐ Yes ☐ No	Hyperpyrexia
☐ Yes ☐ No	CNS infections (meningitis, encephalitis)
☐ Yes ☐ No	Metabolic disturbances (hypoglycemia, etc.)
☐ Yes ☐ No	Convulsive or toxic agents (cloroquine, alcohol)
☐ Yes ☐ No	Cerebral hypoxia (Adams Stokes Syndrome, anesthesia, etc.)
☐ Yes ☐ No	Expanding brain lesions (neoplasm, intracranial hemorrhage, etc.)
☐ Yes ☐ No	Brain defects
☐ Yes ☐ No	Cerebral edema
☐ Yes ☐ No	Anaphylaxis
☐ Yes ☐ No	Cerebral infarction or hemorrhage
☐ Yes ☐ No	Cerebral trauma

Date of last attack	MM / DD / YY	Number of attacks in the last 12 months	

Diagnostic method	Details	
☐ CT scan	Result	
	Treatment	
Date	Prognosis	
MM / DD / YY	Current condition	

Diagnostic method	Details	
☐ MRI	Result	
	Treatment	
Date	Prognosis	
MM / DD / YY	Current condition	
Diagnostic method	Details	
☐ EEG	Result	
	Treatment	
Date	Prognosis	
MM / DD / YY	Current condition	
Diagnostic method	Details	
☐ Arteriography	Result	
	Treatment	
Date	Prognosis	
MM / DD / YY	Current condition	
Diagnostic method	Details	
☐ Tumor excluded	Result	
	Treatment	
Date	Prognosis	
MM / DD / YY	Current condition	
Diagnostic method	Details	
☐ Other	Result	
	Treatment	
Date	Prognosis	
MM / DD / YY	Current condition	

3. TREATING PHYSICIAN'S INFORMATION

Name			
Address			
Telephone		Fax	
Email			
Signature		Date	MM / DD / YY