DukeHealth

New Patient Questionnaire

Name: _____

Date of Birth: _____

Age of first seizure: _____

Last seizure: _____

Handedness: _____Right _____Left _____Both

Seizure risk Factors:

Complication with pregnancy/delivery	_____Yes	_____No
Seizures in infancy	_____Yes	_____No
Seizures associated with fevers in childhood	_____Yes	_____No
Head injuries	_____Yes	_____No
Meningitis or Encephalitis	_____Yes	_____No
Relatives(even distant) with seizures	_____Yes	_____No

Previous seizure medications: _____

Current seizure medications: _____

Medication side effects: _____

Previous Testing

MRI brain Date:_____ Where done:_____

Results: _____

EEG: Date:_____ Where done:_____

Results: _____

Video or Ambulatory EEG: Date:_____ Where done:_____

Results: _____

PET: Date:_____ Where done:_____

Results: _____

SPECT: Date:_____ Where done:_____

Results: _____

NEUROPSYCH: Date:_____ Where done:_____

Results: _____

OTHER: Date:_____ Where done:_____

Results: _____

Injuries with seizures: _____

_____

_____

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