

Questionnaire for Seizure History

Child Name _____

Birth Date _____

Gender _____

Please answer all questions. If you have been told that you have additional information

When was your child diagnosed with seizure disorder? _____

What type of seizure does your child experience? _____

What symptoms does your child experience during a seizure? _____

Is your child aware of an aura (distortion of vision, ringing or silence) before a seizure? ☐ Yes ☐ No

Does your child lose consciousness during a seizure? ☐ Yes ☐ No

How often does your child experience a seizure? _____

How does your child's seizure typically begin? _____

When was your child's last seizure? (Date) _____

Has your child experienced a seizure lasting longer than five minutes? ☐ No ☐ Yes (Please explain) _____

Has your child ever gone to the emergency room or been hospitalized for a seizure? ☐ No ☐ Yes (Please explain) _____

What events might trigger a seizure? _____

What medications does your child take to manage his/her seizure disorder?

Name of medication _____

Amount _____

When taken _____

Name of medication _____

Amount _____

When taken _____

Name of medication _____

Amount _____

When taken _____

Has your child ever missed school or work because of a seizure? ☐ No ☐ Yes

Are there any other factors that might trigger a seizure? ☐ No ☐ Yes

(Please explain) _____

Is your child participating in sports or school activities? ☐ Yes ☐ No (Please explain) _____

Is your child comfortable alerting others when experiencing symptoms of a possible seizure? ☐ No ☐ Yes

Does your child wear a "medical alert" bracelet or necklace? ☐ No ☐ Yes

Describe your child's understanding of his/her seizure disorder. ☐ None ☐ Limited ☐ Basic ☐ Advanced

Has your child ever been hospitalized for a seizure? ☐ No ☐ Yes

(Please explain) _____

Information _____