

# EPILEPSY QUESTIONNAIRE

Please fax back to IPA at 781 643-2775

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

1. Have you ever had, or been told that you had a fainting spell \_\_\_\_\_ seizure \_\_\_\_\_ convulsion \_\_\_\_\_ If so, describe the symptoms and events that took place? \_\_\_\_\_
2. When was your first episode and type: \_\_\_\_\_
3. When was your last episode? \_\_\_\_\_
4. How often do these episodes occur? \_\_\_\_\_
5. Do you lose consciousness? \_\_\_\_\_
6. Do you ever have any warning prior to the event? \_\_\_\_\_
7. Who is your physician? \_\_\_\_\_
8. What medication are you on? \_\_\_\_\_
9. Have you ever had any of the following: Skull x-rays: \_\_\_\_\_ EEG's: \_\_\_\_\_  
CAT Scan: \_\_\_\_\_ Other tests: \_\_\_\_\_
10. Have you ever been told what caused your seizures? \_\_\_\_\_
11. Do you drive? \_\_\_\_\_

Agent Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax No: \_\_\_\_\_

Date: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Please circle the associate you work with. Russ, Rhonda, Leo