

TO BE COMPLETED BY THE ATTENDING PHYSICIAN

1 of 2

Section I. Patient information

1. Last name(s): 2. First name: 3. Middle initial:

4. Date of birth: 5. Gender: Male Female 6. Smoker?: Yes No 7. Cigarettes per day: 8. Since when?: 9. Until when?:

Section II. Symptoms and/or signs of the disease

1. Date of onset:

2. Dizziness Yes No 3. Headache Yes No 4. Fever Yes No 5. Syncope Yes No 6. Auras Yes No

7. Please explain the affirmative answers:

Section III. Results of tests performed to diagnose and monitor the disease

1. Electroencephalogram: 2. Arteriography: 3. CT scan:

4. PET scan: 5. MRI: 6. Functional MRI: 7. SPECT:

8. Laboratory tests:

Glucose: Hemoglobin: Creatinine: Liver function tests:

Section IV. Has the patient had any of the following types of seizure disorders?

FOCAL SEIZURES

1. Simple focal Yes No 2. Complex focal Yes No

GENERALIZED SEIZURES

3. Absence seizures (petit mal) Yes No 4. Myoclonic seizures Yes No 5. Tonic-clonic seizures (gran mal) Yes No

6. Tonic, clonic or atonic seizures Yes No 7. Other Yes No

ETIOLOGY OF THE SEIZURES

8. Primary 9. Secondary

10. Please explain the affirmative answers:

11. Date of last seizure:

12. Frequency of seizures:

Section V. Has the patient had or currently have any of the following?

1. Brain tumor Yes No 2. Cerebrovascular disease Yes No 3. Meningo encephalitis Yes No

4. Metabolic disease Yes No 5. Cerebral Palsy Yes No 6. Developmental disorder Yes No

7. Congenital malformation of the nervous system Yes No

8. Please explain the affirmative answers:

Section VI. Treatment1. Medications Yes No

2. Name:

3. Dose:

4. Name:

5. Dose:

6. Neurosurgeries Yes No

7. Specify the type of surgery, date and evolution:

Section VII. Has the patient been hospitalized for seizures, epilepsy or its complications? Yes No

1. Date:

2. Diagnosis:

M M / D D / Y Y Y Y

Section VIII. Has the patient consulted any other doctor? Yes No

1. Date:

2. Full name:

M M / D D / Y Y Y Y

3. Specialty:

Section IX. Has the patient had any of the following complications?1. Status epilepticus Yes No2. Injuries or accidents during a seizure Yes No3. Hemiplegia Yes No4. Permanent brain damage Yes No

5. Please explain the affirmative answers:

Section X. Attending physician's information

1. Last name(s):

2. First name:

3. Middle initial:

4. Address:

5. Email address:

6. Office phone:

7. Cellular phone:

8. How often do you see the patient?:

9. Signature and seal of the professional:

10. Date:

M M / D D / Y Y Y Y