EEG Intake Questionaire

Name: _____ Date:_____.

Right or Left handed: _____

Do you have a family history of seizures or epilepsy? ☐ Yes ☐ No

If yes, please describe relationship (mother, brother, sister, etc.):

_____
_____
_____

Have you ever had a seizure? ☐ Yes ☐ No

Have you ever had a loss of consciousness? ☐ Yes ☐ No

When did your episodes first begin? _____

When did your last episode occur?_____

Please describe your last episode (ex: shaking, numbness, vomiting, void bladder or bowels):

_____
_____
_____
_____.
_____.
_____.
_____.

What were your symptoms prior to your last episode (feeling of weakness, aura, dizziness, etc.)?

_____
_____
_____

What were your symptoms following the episode (tired, dizzy, confused, disoriented, etc.)?

_____
_____
_____

Did anyone witness the episode? ☐ Yes ☐ No

If yes, how did they describe it?:

_____
_____

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How long did the episode last for?_____ _____.

Did you seek medical attention? ☐ **Yes** ☐ **No**

Have you ever had a concussion or head trauma? ☐ **Yes** ☐ **No**

If so how many?_____ _____.

Do you get headaches often? ☐ **Yes** ☐ **No**

If yes, are they in a specific area of the head? _____ _____

☐ **Pounding** ☐ **Pressure** ☐ **Radiating** ☐ **Stabbing** ☐ **Dull** ☐ **Cluster**

☐ **Other**_____

Have you ever had a stroke? ☐ **Yes** ☐ **No**

Have you ever had a heart attack? ☐ **Yes** ☐ **No**

Please list all of your existing health problems:

_____
_____
_____
_____
_____

Please list all of your current medications