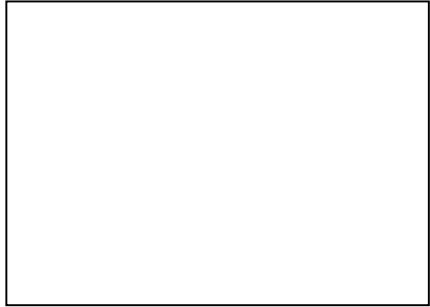


 **EEG Intake Questionnaire**



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

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