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Epilepsy/Syncope History

Date

Name | Date of birth | Age

When was the first seizure? | When was the last seizure?

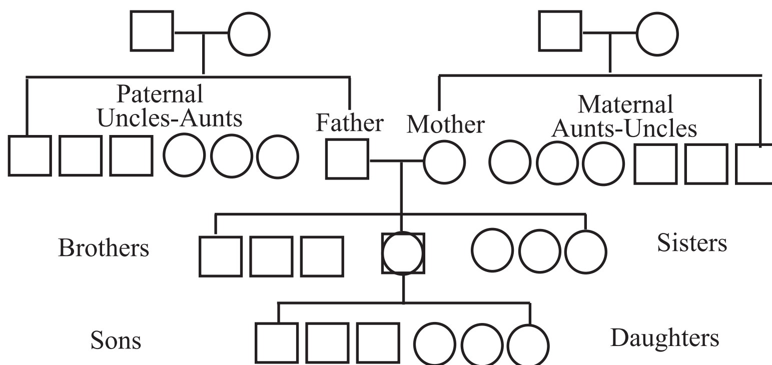
How frequent are the seizures?

Describe the seizures:

Are the seizures associated to these symptoms?

- ☐ Blank Stare
- ☐ Loss of Consciousness
- ☐ Urine incontinence
- ☐ Sleep after Seizure
- ☐ Confusion after Seizure
- ☐ Jerking of extremities

Is there a family History of epilepsy?__ yes __no



Have these tests been performed?

Test	Date	Where	Result
CT Scan ☐			
MRI ☐			
EEG ☐			

Current Seizure Medications:

Name	Unit dose	Morning		Noon		Night	Prescribed by	Side effects

Pregnant? ________No ______Yes