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Epilepsy/Syncope
 History

Date

Name

Date of birth

Age

When was the first seizure?

When was the last seizure?

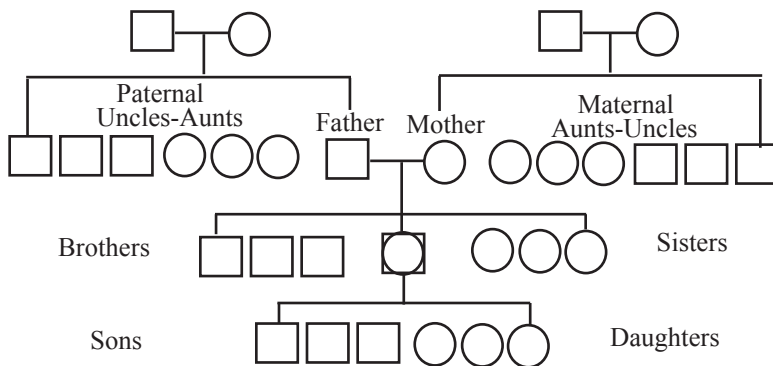
How frequent are the seizures?

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 <input type="checkbox"/> | | | |
| MRI <input type="checkbox"/> | | | |
| EEG <input type="checkbox"/> | | | |

Current Seizure Medications:

| Name | Unit dose | Morning | Noon | Night | Prescribed by | Side effects |
|------|-----------|---------|------|-------|---------------|--------------|
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Pregnant? _____ No _____ Yes