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CNOS
SPECIALIZING IN YOUR HEALTH

575 Sioux Point Road, Dakota Dunes
4802 Sunnybrook Drive, Sioux City

Seizure Questionnaire

Acct # _____

Name:_____ Date of Birth:_____

Date: _____ Physician: _____

Please collect the information listed below and bring it with you to the visit. If possible, bring someone who has seen you have a seizure to the office with you.

1. Make a summary of your seizure history.

   Is there more than one type? Describe each type, including how old you were when they started and how often they occur now. What do they look like to someone else and how do they feel to you?

   Type A: _____

   _____

   _____

   Type B: _____

   _____

   _____

   Type C: _____

   _____

   _____

2. Record on the calendar, on the reverse side of this sheet, all of your seizures during the past month. Include what time of day. Do they arise from sleep or while awake? Estimate length. Note any other features you feel to be relevant.

3. List all seizure medicines you have taken in the past and how each one affected you and the seizures.
   1. _____
   2. _____
   3. _____
   4. _____